

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. **XX**

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fort Howard Veterans Hospital				STREET ADDRESS (If rural, give location) 644 W. Fayette Street			
3. NAME OF DECEASED (Type or Print)		(First) August		(Middle) Robert		(Last) Abicht	
4. DATE OF DEATH		(Month) January		(Day) 16,		(Year) 1951	
5. SEX male		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced		8. DATE OF BIRTH Aug. 31, 1910	
9. AGE last birthday 40 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Abicht		14. MOTHER'S MAIDEN NAME Louise Abicht			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-03-3834		17. INFORMANT Mr. Elmore C. Abicht 1656 Northgate Rd.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause Fatty liver							
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE Stanley H. Overholser				M.D. 700 Fleet St., Baltimore 2, Md.		DATE SIGNED Jan. 17, 1951	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1/19/51		Balto. Nat'l Cem.		Baltimore, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
1/18/51		Wm. J. Tedlow		Wm. J. Tedlow, Sons Inc North. Cal. Ave.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

574 246

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Turners Station</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Turners Station</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1157 N. Main St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Joseph</u> (Middle) <u>Maurice</u> (Last) <u>Adams</u>	4. DATE OF DEATH (Month) <u>1</u> (Day) <u>29</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>11-30-50</u>
9. AGE last birthday yrs. <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Balto. City, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Arthur Harris</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Rose Jones - 1709 Appleton St.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Lobar pneumonia</u>		<u>2 days</u>	
Antecedent cause(s) (b) <u>none</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/28/51</u> , 19....., to <u>1/29/51</u> , 19....., that I last saw the deceased alive on <u>January 29, 1957</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Fit Thomas</u>		ADDRESS <u>107 N. Main St Dundalk Md</u>	
DATE SIGNED <u>1/31/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/1/51</u>	<u>Whitman Mem. Park</u>	<u>Balto. County Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2/1/51</u>		<u>Charles L. Law</u>	<u>802 N. Main St.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0157
Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		LENGTH OF STAY (In this place) <u>30 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5. N. ROLLING RD</u>				STREET ADDRESS (If rural, give location) <u>5 N ROLLING RD.</u>			
3. NAME OF DECEASED (Type or Print) <u>CHRISTIAN</u>		(First) <u>W.</u>		(Middle) <u>ALBRACHT</u>		(Last)	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>SEPT. 3, 1889</u>	
9. AGE last birthday <u>61</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>BROOKLYN New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CONRAD ALBRACHT</u>		14. MOTHER'S MAIDEN NAME <u>CAROLYN UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>216 01 8700</u>		17. INFORMANT <u>HELENE T. ALBRACHT</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION **19b. MAJOR FINDINGS OF OPERATION**

INTERVAL BETWEEN ONSET AND DEATH

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		(CITY OR TOWN) <u>Catonsville</u>		(COUNTY) <u>Baltimore</u>		(STATE) <u>MD</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan 4 1957 11:20 a.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Hanging from rope from ceiling in shed</u>					

22. I certify that I took charge of the remains described above, held an Autopsy ☐ **Inspection** ☐ **Inquiry** ☒ **thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:** natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>JAN. 6, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>MORRIS PARK</u>		LOCATION (City, town, or county) <u>BALTIMORE, MD</u>		(State)	
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DATE REC'D BY LOCAL REG. <u>Jan 5 1957</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>J. J. Conner Jr.</u>		ADDRESS <u>1329 Sulphur Spring Rd.</u>	
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>		STREET ADDRESS (If rural, give location) <u>714 W. Lexington St.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Carlton</u> (Middle) (Last) <u>Allen</u>		(Month) <u>Jan.</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1/5/1916</u>
9. AGE last birthday <u>35</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Acetylene Burner</u>	
11. BIRTHPLACE (State or foreign country) <u>Atlanta, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Allen</u>		14. MOTHER'S MAIDEN NAME <u>Leslie Edwards</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>248-01-8967</u>	
17. INFORMANT AND ADDRESS <u>Carlton Allen, 714 W. Lexington St. Balto., Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Pulmonary Tuberculosis, Far Advanced.</u> About 3 yrs			
Antecedent cause(s) (b) <u>None</u>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>None</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/31</u> , 19 <u>49</u> , to <u>1/29</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1/29</u> , 19 <u>51</u> , and that death occurred at <u>6:45</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>William Newman</u> M.D.		ADDRESS <u>Mt. Wilson, Md.</u>	
DATE SIGNED <u>1/29/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/1/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Eastside Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rockingham N.C.</u>	
24. REGISTRAR'S SIGNATURE <u>John R. Mayer</u>		25. FUNERAL DIRECTOR <u>Don Sedberry, Rockingham, N.C.</u>	
DATE REC'D BY LOCAL REG. <u>1/29/51</u>		ADDRESS	

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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0159

Reg. Dist. No. **38**

1. PLACE OF DEATH- COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD COUNTY BALTO	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON		CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8419 LOCH RAVEN BLVD.		STREET ADDRESS (If rural give location) 8419 LOCH RAVEN BLVD.	
3. NAME OF DECEASED (Type or Print) FRANKLIN BURNETT ANDERSON	(First) (Middle) (Last)	4. DATE OF DEATH JAN. 23 1951	(Month) (Day) (Year)
5. SEX M	6. COLOR OR RACE W	7. SINGLE , MARRIED , WIDOWED , DIVORCED , (Specify)	8. DATE OF BIRTH 8/31/1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CHARLES W. ANDERSON		14. MOTHER'S MAIDEN NAME OZELLO BURNETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY No. WORLD WAR I -- NONE	
17. INFORMANT MRS. WILMA M. ANDERSON - 8419 LOCH RAVEN		18. MEDICAL CERTIFICATION 567D	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Heart disease: vascular coronary occlusion, sudden		Sudden	
Antecedent cause(s) (b) 430.1 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE Rollin B. Hudson M.D., D.M.E. Towson Md		DATE SIGNED 1/24/51	
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF 1/26/51	NAME OF CEMETERY OR CREMATORY ST. JAMES CEM.	LOCATION (City, town, or county) MY LADY'S MANOR, MD
DATE REC'D BY LOCAL REG. 1/25/51	REGISTRAR'S SIGNATURE A. W. Hudson	24. FUNERAL DIRECTOR Wm. J. Tucker & Sons	ADDRESS Balto (17) Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *45*

0160

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>209 Edgewater Apts</u>		STREET ADDRESS (If rural, give location) <u>209 Edgewater Apts.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>HELEN</u>	<u>MARY</u>	<u>ARTHUR</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u> (Specify)	8. DATE OF BIRTH <u>1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
13. FATHER'S NAME <u>John L. Finnessy</u>		14. MOTHER'S MAIDEN NAME <u>Maud Murphy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Mr. Jerome Arthur-209 Edgewater Apts.</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Pulmonary edema.</u>	<u>5 min</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Myocarditis.</u>	<u>1 wk</u>
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>History of allergy</u>		<u>3 yrs ago</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
<u>HOMICIDE</u>	<u>INJURY</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/2, 1957, to 1/5, 1957, that I last saw the deceased alive on 1/5, 1957, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

SIGNATURE <u>Conrad H. Richter M.D.</u>	DATE THEREOF <u>1/9/57</u>	NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	LOCATION (City, town, or county) (State) <u>Baltimore City</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE REC'D BY LOCAL REG. <u>1/8/57</u>	REGISTRAR'S SIGNATURE <u>G. W. Pedersen</u>	24. FUNERAL DIRECTOR <u>WIEDEFELD & SON</u> GREENMOUNT AVE & 22ND

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 238

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural: Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium Towson 4, Maryland</u>		STREET ADDRESS (If rural, give location) <u>4207 Kneeland Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Caroline</u> (Middle) <u>E</u> (Last) <u>AVERY.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jun 7 1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, (MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 24, 1905</u>
9. AGE last birthday <u>45</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Alfred Cannel</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT Personal History-Hospital Records, Eudowood Sanatorium			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause (a) <u>Pulmonary Tuberculosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>17 yr + 10</u>
Antecedent cause(s) (b) <u>002x 13b</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-6, 1951, to 1-7, 1951, that I last saw the deceased alive on 1-7, 1951, and that death occurred at 5:10 p.m., from the causes and on the date stated above.

SIGNATURE W. A. Bridges (Degree or title) M.D., Supt., Eudowood Sanatorium, Towson 4, Md. ADDRESS Edgehill Cem., Edgehill, Virginia DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>Jan. 11, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Edgehill Cem.</u>	LOCATION (City, town, or county) (State) <u>Edgehill, Virginia</u>
DATE REC'D BY LOCAL REG <u>1/10/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>William Cook, Inc.</u>	ADDRESS <u>1217 St. Paul St.</u>

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Parkville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2907 Alden Road</u>		STREET ADDRESS (If rural, give location) <u>2907 Alden Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Peter V. Barrett</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 14 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Married</u>	8. DATE OF BIRTH <u>Aug 9-1862</u>
9. AGE last birthday <u>88</u> yrs.		10. AGE last birthday If under 1 year: Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>2.</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Mr. Louis Barrett, 2907 Alden Rd</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		?
Immediate cause (a) <u>Arteriosclerosis, generalized</u>		
Antecedent cause(s) (b) <u>450.0</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>97</u>		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1943, to January 13, 1951, that I last saw the deceased alive on January 13, 1951, and that death occurred at 650 P m., from the causes and on the date stated above.

SIGNATURE James M.D. (Degree or title) ADDRESS 6217 Harford Rd Baltimore - 14, Md DATE SIGNED 1/15/51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/17/51</u>	<u>Calvary</u>	<u>Cleveland, Ohio</u>
DATE REC'D. BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1/15/51</u>	<u>A.M. Bacon</u>	<u>H. J. Luck</u>	<u>5305 Harford Rd 970 VIV</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

3009 Northway dr



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0163 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>418 Virginia Ave</u>		STREET ADDRESS (If rural, give location) <u>418 Virginia Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Bessie Beauder Beauder</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar 26-1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>73</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Cambridge Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Martha Lee - 418 Virginia Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Diabetes mellitus

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 2, 1951, to Jan 20, 1951, that I last saw the deceased alive on Jan 20, 1951, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

720826

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5709 Johnnycake Rd.</u>		STREET ADDRESS (If rural, give location) <u>5709 Johnnycake Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN BICKFORD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 27, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 26, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R.</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>
13. FATHER'S NAME <u>Bickford</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-7802</u>	
17. INFORMANT AND ADDRESS <u>5709 Johnnycake Rd.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) MYOCARDIAL DEGENERATION

WITH CARDIAC DECOMPENSATION.

INTERVAL BETWEEN ONSET AND DEATH

1(?)yr

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY — INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 13, 1951, to Jan. 27, 1951, that I last saw the deceased

alive on Jan. 26, 1951, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-28-51

T. E. Harris

Easton Sons, Catonsville

1/27/51

690 506

MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



0165

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u> <u>MD</u> TOWN <u>SPARROWS POINT</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Both Steel Dispensary</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>DELAWARE</u> COUNTY <u>NEW CASTLE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u> TOWN <u>Wilmington</u> STREET ADDRESS (If rural, give location) <u>1821 LOUVERING AVE.</u>													
3. NAME OF DECEASED (Type or Print) <u>Charles S. BLACK</u>		4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>11</u> (Year) <u>1951</u>		5. SEX <u>M.</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>Feb 1, 1882</u>		9. AGE last birthday <u>68</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td>If under 1 year</td> <td>If under 24 hrs.</td> </tr> <tr> <td>Months</td> <td>Days Hours Mins.</td> </tr> </table>		If under 1 year	If under 24 hrs.	Months	Days Hours Mins.
If under 1 year	If under 24 hrs.																
Months	Days Hours Mins.																
10a. USUAL OCCUPATION (Give kind of work, date during most of working life, even if retired) <u>Steam Fitter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing Contractor</u>				11. BIRTHPLACE (State or foreign country) <u>Wilmington, Delaware</u>				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>John BLACK</u>				14. MOTHER'S MAIDEN NAME <u>SARAH STEWART</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT <u>JAMES W. ELLIOT, 1815 LOUVERING AVE</u>			
18. MEDICAL CERTIFICATION																	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>CORONARY Occlusion</u> Antecedent cause(s) (b) <u>430.1</u> <u>94a</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)																	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death																	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY				(CITY OR TOWN) (COUNTY) (STATE)									
TIME (Month) (Day) (Year) (Hour) OF INJURY . m.				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				HOW DID INJURY OCCUR?									
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>.																	
SIGNATURE <u>John S. Davis M.D.</u>				(Degree or title) <u>Dep. Med. Exam.</u>				ADDRESS <u>Wilmington, DE.</u>				DATE SIGNED <u>1/11/51</u>					
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>				DATE THEREOF <u>JAN. 16, 1951</u>				NAME OF CEMETERY OR CREMATORY <u>Wilmington + BRANDYWINE</u>				LOCATION (City, town, or county) (State) <u>Wilmington, Delaware</u>					
DATE REC'D BY LOCAL REG. <u>January 13th 1951</u>				REGISTRAR'S SIGNATURE <u>R.W.</u>				24. FUNERAL DIRECTOR <u>John & Mitchell Sons Inc.</u>				ADDRESS <u>1900 Eutaw Pl.</u>					

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE North Carolina		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Howard		LENGTH OF STAY in this place 29 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sanford			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.				STREET ADDRESS (If rural, give location) 214 Steel Street			
3. NAME OF DECEASED (Type or Print) FRANK		(First)		(Middle) I.		(Last) BIALOCK	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 12-21-20	
						9. AGE last birthday 30 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Anson Co., N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Merritt Blalock, Sr.				14. MOTHER'S MAIDEN NAME Mary Eula Ivey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW II		16. SOCIAL SECURITY No. 238-12-9141		17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

2041 Immediate cause (a) MYELOID LEUKEMIA
Antecedent cause(s) (b)
74a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH
2 years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec. 21, 1950, to Jan. 19, 1951, and that death occurred at 5:38 A.M., from the causes and on the date stated above.

SIGNATURE Paul Padget (Degree or title) ADDRESS DATE SIGNED

PAUL PADGET, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND 1-19-51

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 1-20-51	NAME OF CEMETERY OR CREMATORY Buffalo Cemetery	LOCATION (City, town, or county) Sanford, N. C.	(State)
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DATE REC'D BY LOCAL REG. Jan. 19-51	REGISTRAR'S SIGNATURE Dawson L. Barber	24. FUNERAL DIRECTOR Mildred T. Blight	ADDRESS Howard Blight Funeral Home 6009 Harford Road, Baltimore 14, Md.
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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *32*

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Owings Mills		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Owings Mills	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood Lane		STREET ADDRESS (If rural, give location) Rosewood Lane	
3. NAME OF DECEASED (Type or Print) Catherine H Bleakley		4. DATE OF DEATH Jan. 29, 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Sept. 1, 1868
9. AGE last birthday 82 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Carroll Co.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Isaac Simmons		14. MOTHER'S MAIDEN NAME Mary Shipley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Theresa Bleakley, Owings Mills			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause 422.1 Chronic myocarditis	INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs
Antecedent cause(s) 93d Antero sclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Dec 27*, 19*50*, to *1-27-*, 19*51*, that I last saw the deceased alive on *1-26-*, 19*51*, and that death occurred at *5:30 A*.m., from the causes and on the date stated above.

SIGNATURE <i>Dr. E. E. Michael</i>	(Degree or title)	ADDRESS <i>Reisterstown, Md.</i>	DATE SIGNED <i>1-29-51</i>
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Jan. 31, 1951	NAME OF CEMETERY OR CREMATORY St. Thomas	LOCATION (City, town, or county) (State) Baltimore Co.
DATE REC'D BY LOCAL REG. <i>1-29-51</i>	REGISTRAR'S SIGNATURE <i>Dr. E. E. Michael</i>	24. FUNERAL DIRECTOR J.F. Eline & Sons, Reisterstown, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eastport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>615 2nd Street</u>	
3. NAME OF DECEASED (Type or Print) <u>MOSES</u> (First) (Middle) (Last) <u>BOOZE (ALSO BOOTH)</u>		4. DATE OF DEATH <u>January 3</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-2-82</u>
9. AGE last birthday <u>68</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Booth</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pindell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CARDIAC DILATATION AND HYPERTROPHY

INTERVAL BETWEEN ONSET AND DEATH

2 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 19, 1950, to Jan. 3, 1951. ~~that I last saw the deceased~~

live on and that death occurred at 12:10 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, MD. ACT. CHIEF MEDICAL SERVICE VAH FT. HOWARD, MD.

1-4-51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

J. B. Johnson 34 Lockwood Avenue
Annapolis, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

730 869

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C. BALTIMORE</u> COUNTY <u>141</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
TOWN <u>PIKESVILLE</u>		TOWN <u>PIKESVILLE MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AUGSBURG HOME</u>		STREET ADDRESS (If rural, give location) <u>CAMPFIELD ROAD</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>EMMA</u> (Middle) <u>BORNMANN</u> (Last) <u></u>		4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>JUNE 26 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	9. AGE last birthday <u>73</u> yrs. If under 1 year Months. Days Hours Min.
13. FATHER'S NAME <u>JOHN DEICHMILLER</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If year, give war or dates of service) <u></u>		12. CITIZEN OR WHAT COUNTRY? <u>US</u>	
16. SOCIAL SECURITY NO. <u></u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE ENGELHAUPT</u>	
17. INFORMANT <u>AUGSBURG HOME RECORDS</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Thrombosis</u>			<u>Immediate</u>
420.1 Antecedent cause(s) (b) <u>Hypertensive Cardio-Vascular Disease</u>			<u>10 yrs.</u>
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u></u>	
21. ACCIDENT (Specify) <u></u> PLACE (Home, farm, factory, street, OF office bldg., etc.) <u></u> (CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u> m. INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u></u>	

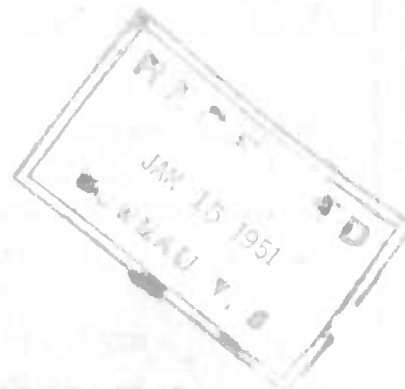
22. I hereby certify that I attended the deceased from Oct., 1942, to Jan. 12, 1951, that I last saw the deceased alive on Dec. 10, 1950, and that death occurred at 1 P. m., from the causes and on the date stated above.

SIGNATURE <u>Earl L. Chambers</u> M.D.		ADDRESS <u>4108 Liberty Hts. Baltimore - 7 - Md.</u>	
DATE SIGNED <u>JAN 15 - 51</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>ST PAULS CEM</u>	
DATE REC'D BY LOCAL REG. <u>January 13 1951</u>		LOCATION (City, town, or county) <u>VIOLETTSVILLE MD</u>	
REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Mrs CHAS A. G. RONDE</u> ADDRESS <u>8327 EDMONDS AVE</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Former residence obtained by phone from the Augsburg Home - 2-13-51. ams.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u> LENGTH OF STAY (in this place) <u>26 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>210 HILTON AVE</u>		STREET ADDRESS (If rural, give location) <u>210 Hilton Ave</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOSEPH HARRY BRAND SR.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 11, 1957</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>6/3/1882</u>
9. AGE last birthday <u>68</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Henry Brand</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Joseph H. Brand Jr.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>9 MONTHS</u>
Immediate cause (a) <u>CARCINOMATA OF THE TONGUE.</u>			
Antecedent cause(s) (b) <u>141x</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>45b</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>no</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 8, 1950</u> , to <u>Jan 9, 1957</u> , that I last saw the deceased alive on <u>Jan - 9, 1957</u> , and that death occurred at <u>2 A. M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. S. Lloyd Johnson M.D.</u>		ADDRESS <u>Catonville Md</u>	
DATE SIGNED <u>1/12/57</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>		DATE <u>1/15/57</u>	
NAME OF CEMETERY OR CREMATORY <u>New Calverton</u>		LOCATION (City, town, or county) (State) <u>BALTO CITY</u>	
DATE REC'D BY LOCAL REG. <u>1-12-57</u>		REGISTRAR'S SIGNATURE <u>E. Harry</u>	
24. FUNERAL DIRECTOR <u>Mac Nabband Son</u>		ADDRESS <u>?</u>	

390 926

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

436



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sparks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sparks</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Duncan Hill Road</u>		STREET ADDRESS (If rural, give location) <u>Duncan Hill Rd.</u>	
3. NAME OF DECEASED (First) <u>Addie</u> (Middle) <u>Brooks</u> (Last) <u>Brooks</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6 May 1879</u>
9. AGE last birthday <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maldon Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshua Young</u>		14. MOTHER'S MAIDEN NAME <u>Clarissa Conley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Mellie Jackson, Sparks, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
154x Immediate cause (a) <u>Anemia</u>			<u>6 mons.</u>
46d Antecedent cause(s) (b) <u>Cancer of G. I. tract (Rectum)</u>			<u>5 mons.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic Heart Disease</u>			<u>3 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1948, 19....., to Jan 16, 1951, that I last saw the deceased alive on 16 Jan, 1951, and that death occurred at 11:45 A m., from the causes and on the date stated above.

SIGNATURE Walter T. Kees (Degree or title) M. D. ADDRESS Cockeysville Md. DATE SIGNED 16 Jan 51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>11/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>Stephenson's Chapel</u>	LOCATION (City, town, or county) <u>Sparks, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/17/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Wm. E. Chetman</u>	ADDRESS <u>1701 McCulloch St. Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0172 38

1. PLACE OF DEATH:

County BaltimoreCity or town Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sister Mary Cosmas Brutscher

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteSingle

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 4, 18608. AGE: Years Months Days If less than one day
91 - 13 _____ hrs. _____ min.9. Birthplace Waterloo, N.Y.
(Town, county, and state)10. Usual occupation Housework11. Industry or business (retirement)12. Name Michael Brutscher13. Birthplace Germany14. Maiden name Mary Thomas15. Birthplace Germany16. Informant Sr. Mary ClaraAddress Notch Cliff17. BURIAL Date thereof 1-19-51
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory NOTCH CLIFF CEM.Location NOTCH CLIFF18. Funeral director Charles S. SeilerAddress 901 S. Conkling St. Balto., Md.19. 1-18 57 _____
(Date rec'd by registrar) 19 _____ Registrar L

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 19 51 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 24 19 31 to Jan 17 19 51and that I last saw him alive on Jan 16 19 51Immediate cause of death Pneumonia (Atypical)

DURATION

2 days

Due to _____

Due to _____

Other conditions _____

492x
109 (Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thos. Seiler M.D.
M. D. or other _____Address 28 Allegheny Ave., Towson Date signed _____

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **30**

1. PLACE OF DEATH: COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peace in Pines Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>105 Rosewood Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Lucy</u> (Middle) <u>Bunting</u> (Last) <u>Bunting</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>7/14/1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days Hours Min.
13. FATHER'S NAME <u>Edward Hagmaker</u>		12. CITIZEN OF WHAT COUNTRY? <u>Winchester Va.</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ruth K. Maddox</u>	
17. INFORMANT AND ADDRESS <u>Catonville Md.</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
593x Immediate cause (a) <u>Bronchial Pneumonia</u>		<u>3 Days</u>
93e Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Myocarditis</u>		<u>8 mo.</u>
(c) <u>nephritis</u>		<u>?</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>42</u> , to <u>Jan 21</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Jan 21</u> , 19 <u>50</u> , and that death occurred at <u>6:00 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Wm. H. L. Ford</u>		ADDRESS <u>20 S. Benton St. - Baltimore</u>	
DATE SIGNED <u>2.11.50</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/24/51</u>	<u>Mt. Hope</u>	<u>Va.</u>
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1/24/51</u>	<u>A. W. Hedrick</u>	<u>Wm. Cook, Inc. 1217 St. Paul St.</u>	<u>Baltimore</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Long Green</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Long Green</u>	
TOWN <u>Long Green</u>		TOWN <u>Long Green</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Long Green Rd + Kane Rd</u>		STREET ADDRESS (If rural give location) <u>Long Green Rd + Kane Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Alma</u>	(First) <u>V</u> (Middle) <u>Burnett</u> (Last)	4. DATE OF DEATH	(Month) <u>Jan</u> (Day) <u>9</u> (Year) <u>1957</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 15 - 1887</u>
9. AGE last birthday <u>63 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milliner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Fashion Millinery</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Co. md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Crawton Fowler</u>	14. MOTHER'S MAIDEN NAME <u>Vinona German</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)
16. SOCIAL SECURITY No. <u>217-09-9087</u>	17. INFORMANT <u>Mr. James Burnett Long Green Rd + Kane Rd</u>	18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

481x Immediate cause (a) Coronary Thrombosis
94a Antecedent cause(s) (b) Grippe + Bronchitis
stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH 40 minutes

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec 1, 1950, to Aug, 1957, that I last saw the deceased alive on Aug, 1957, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

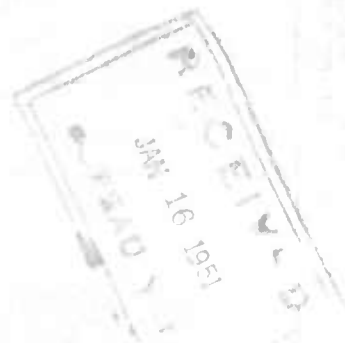
DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>11/12/51</u>	<u>Par. Wood</u>	<u>Balto</u>	<u>md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan. 10, 1957</u>	<u>Alma Burnett</u>	<u>Lasschu Funeral Home 7401 Belbin Rd Balto Co md</u>		

033448

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>113 Beaumont Ave</u>		STREET ADDRESS (If rural, give location) <u>113 Beaumont Ave</u>	
3. NAME OF DECEASED (First) <u>Bessie</u> (Middle) <u>Kimberly</u> (Last) <u>Burt</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/6/1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>74</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>(Unknown) Kimberly</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Henry P. Burt 113 Beaumont Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4221 Immediate cause

(a) Arteriosclerotic cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH

5 years

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1947, 19....., to 8 Jan, 1951, that I last saw the deceased

alive on 8 Jan, 1951, and that death occurred at 8:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, or other disposal (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/12/51</u>	<u>Green Mount</u>	<u>Balto. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1-10-51</u>	<u>N</u>	<u>Wm Cook Inc. 1217 St. Paul St.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0170 38

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Stoneleigh</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>	
TOWN <u>Stoneleigh</u> LENGTH OF STAY (in this place) <u>27 YRS.</u>		TOWN <u>Stoneleigh</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>600 Stoneleigh Road</u>		STREET ADDRESS (If rural, give location) <u>600 Stoneleigh Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>ROBERT</u> (Middle) <u>WELLS</u> (Last) <u>BUSICK</u>		4. DATE OF DEATH (Month) <u>JANUARY</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 30, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COAL</u>	9. AGE last birthday <u>60</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ROBERT TAYLOR BUSICK</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN BURTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-01-1139</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Boris HICKMAN, 45 Dunkirk Rd.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

OCCLUSION OF CORONARY ARTERY

INTERVAL BETWEEN ONSET AND DEATH

2 yrs.

Antecedent cause(s)

(b)

ARTERIOSCLEROTIC HEART DISEASE5 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

NONE

19b. MAJOR FINDINGS OF OPERATION

NONE

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

NONEPLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1st, 1951, to JAN 8, 1951, that I last saw the deceasedalive on JAN 8, 1951, and that death occurred at 11:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

BURIAL

DATE THEREOF

12-11-1951

NAME OF CEMETERY OR CREMATORY

DRUID RIDGE

LOCATION (City, town, or county)

PIKESVILLE

(State)

MD.

DATE REC'D BY LOCAL REG.

1/9/51

REGISTRAR'S SIGNATURE

G. W. H. HUGH

24. FUNERAL DIRECTOR

H.W. JENKINS & Sons Co. 4905 York Rd.

ADDRESS

490697

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *42*

0177

1. PLACE OF DEATH: COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>4722 Aldgate Green</i>		STREET ADDRESS (If rural, give location) <i>4722 Aldgate Green</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Louise</i>	(Middle) <i>B.</i>	(Last) <i>Butler</i>
4. DATE OF DEATH	(Month) <i>January</i>	(Day) <i>5,</i>	(Year) <i>1951</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>Dec. 4, 1902</i>
9. AGE last birthday <i>48</i> yrs.		10. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Carl Brohmeyer</i>		14. MOTHER'S MAIDEN NAME <i>Louise Kupisch</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>none</i>	
17. INFORMANT AND ADDRESS <i>Andrew Butler, 4722 Aldgate Green</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Sarcoma Right Lung

Antecedent cause(s)

(b)

Sarcoma Rt. Breast

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *June 2, 1948* to *Jan 5, 1951*, that I last saw the deceased alive on *Jan 5, 1951*, and that death occurred at *4 P* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>burial</i>	<i>1/9/51</i>	<i>Parkwood Cemetery</i>	<i>Parkville, Maryland</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>1/9/51</i>	<i>R. W. Holmick</i>	<i>H. M. Cook, Inc.</i>	<i>1217 St. Paul Street</i>

ST ✓

093888

MARGIN RESERVED FOR BINDING

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VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
TOWN <u>Towson</u>		TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>316 E. Joppa Road</u>		STREET ADDRESS (If rural give location) <u>316 E Joppa Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Katharine</u> (Middle) <u>H</u> (Last) <u>Carroll</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May 17 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Heinemann</u>		14. MOTHER'S MAIDEN NAME <u>Mary Marischen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Helen C. Koll 316 E Joppa Road</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Occlusion</u>			
940 Antecedent cause(s) (b) <u>Arteriosclerosis, hypertension</u>			<u>several years</u>
11. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 14, 1951, to Jan 17, 1951, that I last saw the deceased alive on Jan 17, 1951, and that death occurred at 9 p.m., from the causes and on the date stated above.

SIGNATURE <u>P. C. Sellman M.D.</u>		ADDRESS <u>600 Baltimore Ave. Towson Md</u>		DATE SIGNED <u>Jan 17, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>1/20/51</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)	
DATE REC'D BY LOCAL REG. <u>1-19-51</u>	REGISTRAR'S SIGNATURE <u>R</u>	24. FUNERAL DIRECTOR <u>W. W. Meekes and Son</u>	ADDRESS <u>805 N. Calvert St.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0179

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparks (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Register with Park Raven Blvd.</u>		STREET ADDRESS (If rural give location) <u>Quaker Bottom Road</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>James</u> (Middle) <u>Albert</u> (Last) <u>Causion</u>		(Month) <u>Jan</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>7-16-1898</u>
9. AGE last birthday <u>52</u> yrs.		10. IF under 1 year Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furin</u>	
11. BIRTHPLACE (State or foreign country) <u>Sparks, Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Causion</u>		14. MOTHER'S MAIDEN NAME <u>Mary Causion</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Seclonia Causion, Sparks, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Heart disease, acute myocarditis with failure. Sudden</u>			
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>431x 93a</u>			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Rollin C. Hudum MD. D.M.E.</u>		DATE SIGNED <u>4/9/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-11-51</u>	
NAME OF CEMETERY OR CREMATORY <u>Stevenson A.M.E.</u>		LOCATION (City, town, or county) (State) <u>Sparks, Balto. Co., Md.</u>	
DATE REC'D BY LOCAL REG. <u>7/17/51</u>		24. FUNERAL DIRECTOR <u>J. Scott Brooks, Sparks, Md.</u>	

820105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

Division

RECEIVED
JAN 16 1951
K. READ V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>920 W. North Ave.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>LAWRENCE</u> <u>M.</u> <u>CORBETT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 27</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-12-96</u>
9. AGE last birthday <u>54</u> yrs.		10. If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milk Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Milk</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Corbett</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia McHale</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.0 Immediate cause (a) <u>CONGESTIVE HEART FAILURE</u>	6 week s
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>30d</u> (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>	UNKNOWN

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 25, 1951, to Jan. 27, 1951, that I last saw the deceased alive on Jan. 27, 1951 and that death occurred at 9:30 P.m., from the causes and on the date stated above.

SIGNATURE Hubert M. Hoffman (Degree or title) ADDRESS Baltimore, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/31/51</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
DATE REC'D BY LOCAL REG. <u>1/29/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>William J. Tickner</u>	ADDRESS <u>North & Pennsylvania Ave. Baltimore, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Baltimore County</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u> Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Daughter of Eucharyst Home</u>		STREET ADDRESS (If rural, give location) <u>Maiden Choice Lane</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ELLEN</u>	(Middle) <u>Elizabeth</u>	(Last) <u>DeLahay</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>unmarried</u>	8. DATE OF BIRTH <u>April 23, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>83</u> yrs.
13. FATHER'S NAME <u>CHARLES MARTIN</u>		11. BIRTHPLACE (State or foreign country) <u>St. Marks County MD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
16. SOCIAL SECURITY No.		14. MOTHER'S MAIDEN NAME <u>ELLEN THOMPSON</u>	
17. INFORMANT <u>ELIZABETH KNOCK</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Myocardial failure</u>		<u>36 hrs</u>
Antecedent cause(s) (b) <u>Arteriosclerotic cardio vascular disease</u>		<u>Unknown</u>
(c) <u>Senile cataracts; decubitus ulcers</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 25, 1947, to Jan 3, 1951, that I last saw the deceased alive on Jan 2, 1951, and that death occurred at 8:00 A. m., from the causes and on the date stated above.

SIGNATURE <u>Joseph Lee Hapness MD</u>		DATE SIGNED <u>1-3-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>Jan 5, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	LOCATION (City, town, or county) (State) <u>Balto. Md</u>
DATE REC'D BY LOCAL REG. <u>1-4-51</u>	REGISTRAR'S SIGNATURE <u>Dr. H. H. H. H.</u>	24. FUNERAL DIRECTOR <u>Charles P. Towell</u>	ADDRESS <u>2427 Edmondson Ave.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Former residence obtained by phone from the Daughters of Eucharist Home.

2-13-51 ams

CERTIFICATE OF DEATH

Registered No. **38**
1182

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Jeremiah Amos De Turk*2. DATE
OF
DEATH*11/31/51*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Md.*5. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)*824 Kingston Rd*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

824 Kingston Rd

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*Married*

8. DATE OF BIRTH

*7/28/1886*9. AGE (In years
last birthday)*64*If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Mechanical Engineer Western Electric Co*10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Reading Pa.*12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jeremiah De Turk

14. MOTHER'S MAIDEN NAME

*Katherine (Unknown)*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)*No**W. W. #1*16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Sadie T. De Turk 824 Kingston Rd

18.

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Cornary Thrombosis

420.1 ANTECEDENT CAUSES

(B)

DUE TO

Arteriosclerosis

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan 20*, 1948, to *Jan 31*, 1951, that I last saw the
deceased alive on *Jan 31*, 1951, and that death occurred at *7:45* m., from the causes and on the date stated above.

23A. SIGNATURE

Lawrence C. Posh

M. D.

23B. ADDRESS

6805 York Rd

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)*Burial*

24B. DATE

2/3/51

24C. NAME OF CEMETERY OR CREMATORY

Meadow Ridge

24D. LOCATION (City, town, or county)

Dorsey Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR*Feb 3 1951*

REGISTRAR'S SIGNATURE

R. W.

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cox Inc. 1217 St. Paul St.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

The
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied.
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

6186

38

1. PLACE OF DEATH:

County Baltimore
City or town Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore
City or town Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Sister Mary Anatolia Dietrich

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (c) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) February 14, 1869
8. AGE: Years 81 Months 11 Days 7 If less than one day hrs. min.

9. Birthplace Buffalo N.Y.
(Town, county, and state)
10. Usual occupation Teacher
11. Industry or business Religious
12. Name Christian Dietrich
13. Birthplace Germany
14. Maiden name Margaret Greuel
15. Birthplace Germany

16. Informant Sr. Mary Clara
Address Notch Cliff, Md.
17. Burial Date thereof 1-24-51.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Villa Maria Cemetery
Location Notch Cliff nr Towson, Md.
18. Funeral director Charles S. Zeiler
Address 901 S. Conkling St. Balto. Md.
19. 1/23/51 G. W. Hedrick
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1951 at 10.00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6 1951 to Jan. 21 1951 and that I last saw her alive on Jan. 16 1951.
Immediate cause of death Apoplexy
DURATION 2 wks.
Due to
Due to
Other conditions 334x
83a (Include pregnancy within 3 months of death)
Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE John P. Green Jr. M.D. M. D. or other
Address 28 Allegheny Ave. Towson Date signed 1/21/51.

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>New York</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Long Island</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Sheppard & Enoch Pratt Hosp.</u>		STREET ADDRESS (If rural, give location) <u>10 Genesee Blvd., Atlantic Beach</u>	
3. NAME OF DECEASED (First) <u>Emma</u> (Middle) <u>Helen</u> (Last) <u>Doerschuck</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>18</u> (Year) <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 31, 1881</u>
9. AGE last birthday <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gustave Doerschuck</u>		14. MOTHER'S MAIDEN NAME <u>Julia Claus</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>HOSPITAL RECORDS</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Broncho pneumonia</u>	INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u>
Antecedent cause(s) (b) <u>Chronic myocardial degeneration</u>	<u>10 yr +</u>
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>Generalized arterio sclerosis</u>	<u>10 yr +</u>
11. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) <u>Dementia praecox</u>	<u>15 yr +</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1940, to Jan 18, 1951, that I last saw the deceased alive on Jan 18, 1951, and that death occurred at 8:55 A.M., from the causes and on the date stated above.

SIGNATURE W. E. Elgin, M.D. (Degree or title) ADDRESS THE SHEPPARD & ENOCH PRATT HOSPITAL DATE SIGNED 1/18/51

23. REMOVAL OR CREMATION (Specify) <u>Removal</u>	DATE THEREOF <u>1/18/51</u>	NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	LOCATION (City, town, or county) (State) <u>Brooklyn New York</u>
DATE REC'D BY LOCAL REG. <u>1/18/51</u>	REGISTRAR'S SIGNATURE <u>W. E. Elgin</u>	24. FUNERAL DIRECTOR <u>Wm J. Ticken</u>	ADDRESS <u>1300 North Pa Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2412 Rockwell Avenue</u>		STREET ADDRESS (If rural, give location) <u>2412 Rockwell Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>SALLIE</u>	(Middle) <u>ELIZABETH</u>	(Last) <u>DOYLE</u>
4. DATE OF DEATH	January 14th, 1951		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>2/22/66</u>
9. AGE last birthday <u>84</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William T. Courtney</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Nailor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Carl Doyle 2412 Rockwell Ave, Catons.</u>		Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

MYOCARDIAL DEGENERATION, ARTERIO SCLEROTIC.

INTERVAL BETWEEN ONSET AND DEATH

3 yrs

Immediate cause

(a)

Antecedent cause(s)

SENILITY

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb-12, 1947, to Jan-14, 1951, that I last saw the deceasedalive on Jan-12, 1951, and that death occurred at 11/16/51, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-16-51V E. HarryEaston SonsCatonsville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

439



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Carlynn Ave & Hillside Drive</u>		STREET ADDRESS (If rural, give location) <u>Carlynn Ave. & Hillside Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Clara</u>	(Middle) <u>Virginia</u>	(Last) <u>Emmart</u>
4. DATE OF DEATH	(Month) <u>January</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 16, 1863</u>
9. AGE last birthday <u>87 yrs.</u>		If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Woodlawn, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Luther Timanus</u>		14. MOTHER'S MAIDEN NAME <u>? George</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Dr. L. Lynn Emmart, Carlynn Ave., Woodlawn</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		24 hrs
561.3 Immediate cause (a) <u>Acute cardiac dilatation</u>		
122a Antecedent cause(s) (b) <u>Strangulation of bowel due to ventral hernia</u>		
(c) <u> </u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	(STATE)
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/3/, 1951, to 1/4, 1951, that I last saw the deceased alive on 1/4, 1951, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

SIGNATURE [Signature] ADDRESS 4710 Liberty Heights Ave. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Jan. 6, 1951</u>	<u>Mt. Olive Cemetery</u>	<u>Randallstown, Md.</u>	<u> </u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>January 6, 1951</u>	<u>R.W.</u>	<u>[Signature]</u> <u>4510 Liberty Hgus Ave.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>1308 N. Broadway</u>	
3. NAME OF DECEASED (Type or Print) <u>Wilmer B. Everist or Frank W. Everist</u>		4. DATE OF DEATH <u>January 30</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>March 1886 or 1887</u> 64 or 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	9. AGE last birthday <u>64</u> or <u>65</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Everist</u>		14. MOTHER'S MAIDEN NAME <u>Lillie or Lillian Everist</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records, Catonsville 28, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4221 Immediate cause (a) <u>Cerebral embolus</u>		<u>3 days</u>
93d Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Chronic auricular fibrillation</u>	<u>Unknown</u>
	(c) <u>Arteriosclerotic cardiovascular disease</u>	<u>Unknown</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 28, 1951, to Jan. 30, 1951, that I last saw the deceased alive on Jan. 30, 1951, and that death occurred at 6:10 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>2/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cemetery</u>	LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>
DATE REC'D BY LOCAL REG. <u>2/2/51</u>	REGISTRAR'S SIGNATURE <u>R.W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Am. Cool. Inc.</u>	ADDRESS <u>1217 St. Paul Street</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 33

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>41 Bond Ave.</u>		STREET ADDRESS (If rural, give location) <u>41 Bond Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Elvia Virginia Ferman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 14 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mch. 17, 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	9. AGE last birthday <u>38</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
13. FATHER'S NAME <u>Harry Diggs</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY No. <u>577-18-6506</u>		14. MOTHER'S MAIDEN NAME <u>Emma Williams</u>	
17. INFORMANT AND ADDRESS <u>Henry C. Ferman, Reisterstown, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Congestive Heart Failure</u>			<u>1 mo.</u>
Antecedent cause(s) (b) <u>Hypertensive C-V. Disease</u>			<u>2 yrs.</u>
(c) <u>Chronic Nephritis</u>			<u>2 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>None</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None</u>	
		HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>J. D. Caples Deputy Med Exam.</u>		DATE SIGNED <u>1-15-51</u>	
23. BURIAL, CREMATION, REBURY (Specify) <u>Burial</u>		DATE THEREOF <u>1-18-51</u>	
NAME OF CEMETERY OR CREMATORY <u>Piney Grove</u>		LOCATION (City, town, or county) (State) <u>Balto. Co. Md</u>	
DATE REC'D BY LOCAL REG. <u>1-16-51</u>		24. FUNERAL DIRECTOR <u>J.F. Eline & Sons</u>	
REGISTRAR'S SIGNATURE <u>Mary B. Elme</u>		ADDRESS <u>Reisterstown, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Holbrook		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Holbrook	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Liberty Rd.		STREET ADDRESS (If rural, give location) Liberty Rd.	
3. NAME OF DECEASED (Type or Print)	(First) ALBERT	(Middle)	(Last) FERRELL
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH May 3, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Contractor (owner)		10b. KIND OF BUSINESS OR INDUSTRY Contracting	9. AGE last birthday 76 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elisha Ferrell		14. MOTHER'S MAIDEN NAME Julia Amos	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Mr. Roy Horn - Liberty Rd., Holbrook, Md.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH 6 days
Immediate cause (a) Cerebral hemorrhage			
Antecedent cause(s) (b) 331x			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 83a			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1/15/51**, 1951, to **1/21/51**, 1951, that I last saw the deceased alive on **1/20/51**, 1951, and that death occurred at **5:25 P.m.**, from the causes and on the date stated above.

SIGNATURE Wm. E. Martin		ADDRESS M. W. Randallstown, Md.		DATE SIGNED 1/21/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 1/23/51	NAME OF CEMETERY OR CREMATORY Wards Chapel	LOCATION (City, town, or county) Holbrook, Md.	(State)	
DATE REC'D BY LOCAL REG. 1-22-51		REGISTRAR'S SIGNATURE C		24. FUNERAL DIRECTOR Wm. J. Schuler & Sons Balty.	
				ADDRESS Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> STREET ADDRESS (If rural give location) _____	
3. NAME OF DECEASED (Type or Print) <u>Richard Paul</u>	(First) (Middle) (Last) <u>Finn</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 4</u> <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct 9 1918</u>
9. AGE last birthday <u>32</u> yrs <u>2</u> months <u>26</u> days		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Matthew Finn</u>		14. MOTHER'S MAIDEN NAME <u>Mina Seaper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>1010 Leads on</u>	
17. INFORMANT <u>Hospital Record - Matthew Finn</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) _____

Antecedent cause(s) (b) _____

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Mental deficient since birth

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION _____ **19b. MAJOR FINDINGS OF OPERATION** _____

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) **INJURY**

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) **OF INJURY**

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

(192

Reg. Dist. No. 42

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3312 Hollin Ferry</u>		STREET ADDRESS (If rural give location) <u>319 S. Smallwood St</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Ann</u>	(First) (Middle) (Last)	4. DATE OF DEATH <u>July 3</u>	(Month) (Day) (Year) <u>1957</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar 30 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>73</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
13. FATHER'S NAME <u>Charles Hare</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs W. Fisher 3312 Hollin Ferry</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. EXTERNAL CAUSE WAS

PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Summer Station MD
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred: 122 Sellers Point Rd

How long in hospital or institution: 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore

City or town Summer Station
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 122 Sellers Point Rd
 (If rural, give LOCATION Dundack rd)

2.(a) If veteran, name war WW

3. (a) FULL NAME

Collin Worsham Flournoy

3. (b) Social Security Number

213-07-3600

4. Sex M 5. Color or race col 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Billy Virginia Flournoy
 6. (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) December 17th 1909

8. AGE: Years 41 Months 1 Days 17 It less than one day hrs. min.

9. Birthplace Farmville Va.
 (Town, county, and state)

10. Usual occupation labor

11. Industry or business Steel Mills

12. Name Charles Flournoy

13. Birthplace Virginia

14. Maiden name Gillie Saunders

15. Birthplace Virginia

16. Informant Collin Flournoy

Address 122 Sellers Point Rd.

17. Date thereof 31 3/51
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory local

Location Farmville Va.

18. Funeral director Mrs Robert A. Williams

Address 1129 71 Carroll St

19. 4/31/51 19. 51 Rev Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30th 1951 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3th 1950 to January 30th 1951

and that I last saw him alive on January 30th 1951

Immediate cause of death Carcinoma of both lungs

Due to 3 months

Due to 163x

Other conditions 47d (Include pregnancy within 3 months of death)

Major findings of operations Anteopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr Thomas MD

Address 107 N. Main St Dundack 22 1/30/51

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Cat</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 Linganore Ave.</u>		STREET ADDRESS (If rural give location) <u>11 Linganore Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>John E. Frank</u>	4. DATE OF DEATH <u>Jan. 7, 1951</u>	5. SEX <u>Male</u>	
6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 8, 1888</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tool industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John H. Frank</u>		14. MOTHER'S MAIDEN NAME <u>Jennie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Kathryn Frank 11 Linganore Ave.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <u>430.0 Acute Coronary Occlusion</u>	(a) <u>Acute Coronary Occlusion</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Antecedent cause(s) <u>93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	(b) <u>arteriosclerotic Heart Disease</u>	<u>3 yrs.</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 1, 1950, to Jan. 7, 1951, that I last saw the deceased alive on Jan. 6, 1951, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

SIGNATURE George Sawyer M.D. ADDRESS 4808 Harford Rd. DATE SIGNED Jan. 8, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 10, 1951</u>	<u>Parkwood</u>	<u>Parkville, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1/8/51</u>	<u>A.W. Hedger</u>	<u>Ullrich Funeral Home</u>	<u>2008 Orleans St.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 Enoch Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> TOWN STREET ADDRESS (If rural, give location) <u>8 Enoch Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Alexander</u> (First) <u>Frazier Jr.</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>Jan</u> (Month) <u>19</u> (Day) <u>1951</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Jan. 2 - 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursery School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Towson Md</u>	
11. FATHER'S NAME <u>Alexander Frazier Jr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. MOTHER'S MAIDEN NAME <u>Rachel Winder</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Doctor Frazier - 8 Enoch Ave - Towson</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Carcinoma (- bronchogenic) Right Lung.</u>	<u>11 mo.</u>
Antecedent cause(s)	(b) <u></u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u></u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Oct 1, 1950, to Jan 19, 1951, that I last saw the deceased alive on Jan 19, 1951, and that death occurred at 11:00 m., from the causes and on the date stated above.

SIGNATURE <u>Dr. W. D. Frazier Jr.</u>		ADDRESS <u>Towson - 4 - md</u>		DATE SIGNED <u>1/20/51.</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>Jan. 22 - 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest Cem.</u>	LOCATION (City, town, or county) <u>Towson</u>	(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>1/24/51</u>	REGISTRAR'S SIGNATURE <u>G. W. Hedger</u>	24. FUNERAL DIRECTOR <u>Samuel W. Sullivan Jr.</u>		ADDRESS <u>Baltimore Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

770588

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>2102 N. Calvert St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JAMES</u>	(Middle) <u>M.</u>	(Last) <u>FRENCH</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M-sep.</u>	8. DATE OF BIRTH <u>12-25-95</u>
9. AGE last birthday <u>55</u> yrs.		4. DATE (Month) (Day) (Year) OF DEATH <u>Jan. 29 1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William French</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Moffett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW-1</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Clinical Records Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cerebrovascular accident probably hemorrhage</u>	<u>3 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Hypertensive disease with cerebrovascular accidents</u>	<u>11 yrs.</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Total blindness</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 5, 1951, to Jan. 29, 1951, that I last saw the deceased

live on Jan. 29, 1951 and that death occurred at 9:40A m., from the causes and on the date stated above.

SIGNATURE Paul Padgett (Degree or title) ADDRESS DATE SIGNED
PAUL PADGETT, M.D. CHIEF MEDICAL SERVICE VAH FT. HOWARD, MD. 1-30-51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-1-51</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Va.</u>	LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>
DATE REC'D BY LOCAL REG. <u>Jan 30-51</u>	REGISTRAR'S SIGNATURE <u>Dawson L. Harbor</u>	24. FUNERAL DIRECTOR <u>Chambers Funeral Home, WASH. D.C.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Parkville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8627 Old Harford Road</u>		STREET ADDRESS (If rural, give location) <u>8627 Old Harford Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Henry</u> (Middle) <u>J.</u> (Last) <u>Fuhrman, Sr.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 4th 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 12, 1888</u>
9. AGE last birthday <u>62 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Inspector</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>1951</u>	
13. FATHER'S NAME <u>Henry James Fuhrman</u>		14. MOTHER'S MAIDEN NAME <u>Helen Jane Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>717-07-7338</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Edma Fuhrman, 8627 Old Harford</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

155x

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

46f

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

12-1-51

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-1, 1950 to Jan 4, 1951, that I last saw the deceasedalive on Jan 4, 1951, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1/8/51A. W. HedmanLeonard J. Ruck, 5305 Harford Road.533506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Shimanek

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>B</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mount Wilson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>M Baltimore, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hosp.</u>		STREET ADDRESS (If rural, give location) <u>943 N. Calvert St.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>John</u> (Middle) <u>Crommer</u> (Last) <u>Geist</u>		(Month) <u>Jan.</u> (Day) <u>12,</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2/4/1892</u>
9. AGE last birthday <u>58</u> yrs.		10. If under 1 year Months <u>11</u> Days <u>8</u> If under 24 hrs. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same as above</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Geist</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Crommer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>John Crommer Geist Baltimore, Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis; far advanced

INTERVAL BETWEEN ONSET AND DEATH

About 12

Antecedent cause(s)

(b) Tuberculosis of right hip joint and left femur.About 12
yrs.

(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.19a. DATE OF OPERATION
No operation

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT (Specify)
SUICIDE
HOMICIDEPLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/30....., 1939, to 1/12....., 1951., that I last saw the deceased alive on 1/12....., 1951, and that death occurred at 4:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William M. M. M.

M.D.

Mt. Wilson, Md.1/12/5123. BURIAL, CREMATION REMOVAL (Specify)
BurialDATE THEREOF
1/15/51NAME OF CEMETERY OR CREMATORY
Bosley Church Cem.LOCATION (City, town, or county)
Butler, Md.

(State)

DATE REC'D BY LOCAL REG.
1/12/51

REGISTRAR'S SIGNATURE

Ole R. Mayer

24. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc. 1217 St. Paul St., Balto.

Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

820105



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> , COUNTY <u>Baltimore</u> ,	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Convent of the Mission Helpers of the Sacred Heart.</u>		STREET ADDRESS (If rural, give location) <u>1001 West Joppa Road.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Sister Mary Claude (Catherine M. Geoghegan.)</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 14 1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>March 23, 1883</u>
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Missionary Nun</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Geoghegan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Donnelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Convent Records, 1001 W. Joppa Rd. Towson, Md</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Respiratory failure from Lung</u>		<u>2 wks.</u>	
(b) <u>Uterine Cancer</u>		<u>3 yrs.</u>	
(c) <u>Antecedent cause(s)</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>50</u> , to <u>Jan</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan</u> , 19 <u>51</u> , and that death occurred at <u>8:15</u> Am., from the causes and on the date stated above.			
SIGNATURE <u>Charles J. Donnelly</u>		ADDRESS <u>M.D. 7501 York Road.</u>	
DATE SIGNED <u>11/15/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>JAN 17 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Convent Cemetery</u>		LOCATION (City, town, or county) (State) <u>1001 W. Joppa Rd. Towson, Md.</u>	
DATE REC'D BY LOCAL REG. <u>1-16-51</u>		REGISTRAR'S SIGNATURE <u>L</u>	
FUNERAL DIRECTOR <u>B. Vernon Lemon</u>		ADDRESS <u>4611 Park Heights Ave., Baltimore, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>New Jersey</u> COUNTY <u>Cape May</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stone Harbor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hood Nursing Home 5313 Edmondson Avenue</u>		STREET ADDRESS (If rural, give location) <u>-----</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EMMA MARIE GERHARD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 19, 1951</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>February 6, 1871</u>
9. AGE last birthday <u>79</u> yrs.		10. If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Wenzel</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Roach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. William J. Mayer, Towson, Maryland</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>3 days</u>
Antecedent cause(s) (b) <u>Cerebral Arterio Sclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>-----</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 2, 1951, to Jan 19, 1951, that I last saw the deceased alive on Jan 19, 1951, and that death occurred at 6 PM m., from the causes and on the date stated above.

SIGNATURE James H. Howell ADDRESS Catonsville DATE SIGNED 1-20

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE <u>Jan. 21, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Johnson Funeral Home</u>	LOCATION (City, town, or county) (State) <u>Cape May Court House, N.J.</u>
DATE REC'D BY LOCAL REG. <u>1-20-51</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	24. FUNERAL DIRECTOR ADDRESS <u>John Burns' Sons, Towson, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0201

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 1227 E. Madison Street	
3. NAME OF DECEASED (Type or Print) SAMUEL (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) January 19 19 51	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 6-7-1900
9. AGE last birthday 50 yrs.		10. If under 1 year: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sammy Gilyard		14. MOTHER'S MAIDEN NAME Sarah Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY No. 213-09-1863	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) PULMONARY HEMORRHAGE	MINUTES
Antecedent cause(s) (b) TUBERCULOSIS, CHRONIC, PULMONARY, FAR ADVANCED, ACTIVE	UNKNOWN
(c) BRONCHOCUTANEOUS FISTULA	UNKNOWN
II. OTHER SIGNIFICANT CONDITIONS EMPHYEMA, TUBERCULOUS	UNKNOWN

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug. 23, 1949**, to **Jan. 19, 1951**, that I last saw the deceased

SIGNATURE Paul Padget (Degree or title)		ADDRESS		DATE SIGNED	
PAUL PADGET, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND		1-19-51			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF Jan 22, 1951	NAME OF CEMETERY OR CREMATORY Baltimore National	LOCATION (City, town, or county) Baltimore, Maryland	(State) SC	
DATE REC'D BY LOCAL REG. Jan. 22, 1951	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Ida Snowden	ADDRESS 1129 N. Caroline Street Baltimore, Maryland		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>		STREET ADDRESS <u>1258 Linden Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Katherine</u> (First) (Middle) <u>Gleim</u> (Last)		4. DATE OF DEATH <u>January 22</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>APR. 30 1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9. AGE last birthday <u>91</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>NICHOLAS GLEIM</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE MEYERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. JOHN BAUERNSCHMIDT</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		20 minutes
422.1 Immediate cause (a) <u>Acute Pulmonary Edema</u>		
134a Antecedent cause(s) (b) <u>Generalized Arteriosclerotic Cardio-vascular disease?</u>		
(c) <u>Right Renal Calculus</u>		3 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	21. ACCIDENT SUICIDE HOMICIDE (Specify) <u> </u> PLACE (Home, farm, factory, street, OF office bldg., etc.) <u> </u> (CITY OR TOWN) <u> </u> (COUNTY) <u> </u> (STATE) <u> </u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u> m.	INJURY OCCURRED While at <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u> </u>
22. I hereby certify that I attended the deceased from <u>Jan 15</u> , 19 <u>57</u> , to <u>Jan 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 15</u> , 19 <u>57</u> , and that death occurred at <u>4:20 p.m.</u> , from the causes and on the date stated above.		
SIGNATURE <u>Earl Pass, M.D.</u> (Degree or title)		ADDRESS <u>4001 Wilkens Ave</u> DATE SIGNED <u>1-22-57</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>1/25/57</u>	NAME OF CEMETERY OR CREMATORY <u>LORDEN PARK</u> LOCATION (City, town, or county) <u>BALTIMORE MD</u> (State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>1/28/57</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>J. J. Embury</u> ADDRESS <u>1328 Sulphur Spring Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5912 Liberty Rd.</u>				STREET ADDRESS <u>5912 Liberty Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>FILOMENA</u>		(First) (Middle) (Last) <u>GLORIOSO</u>		4. DATE OF DEATH <u>Jan. 31, 1951</u> 19	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 22, 1866</u>	9. AGE last birthday <u>84</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Philip Fertitta</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Lusco</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY No. <u>---02---</u>		17. INFORMANT AND ADDRESS <u>Mr. Philip Glorioso - 5912 Liberty Rd.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
443x Immediate cause (a) <u>Hypertensive Cardio-Vascular disease</u>							
93d Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Jan. 28, 1951, to Jan. 28, 1951, that I last saw the deceased alive on Jan. 28, 1951, and that death occurred at 1011 N. Charles St. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>	(State) <u>2/2/51</u>
DATE RECD BY LOCAL REG. <u>2/2/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>[Address]</u>	

Dm

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0204

Reg. Dist. No. 42

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2602 Teltan</u>		STREET ADDRESS (If rural, give location) <u>2602 Teltan</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Brucant</u>	(Middle) <u>J</u>	(Last) <u>Glorioso</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-14-1898</u>
9. AGE last birthday <u>55</u> yrs.		4. DATE OF DEATH (Month) (Day) (Year) <u>May 1957</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Frank & Johnson</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Glorioso</u>		14. MOTHER'S MAIDEN NAME <u>Mary Chapman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mary Chapman 2406 Smith</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

Coronary heart disease

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

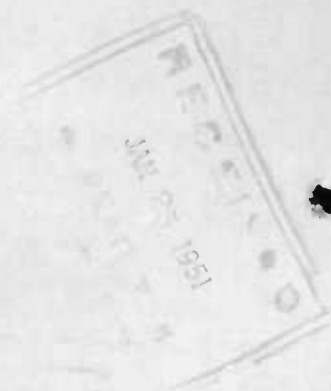
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1-24-57</u>	<u>Catharine</u>	<u>Baltimore</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 57</u>	<u>G. Kieffer</u>	<u>Mr. Cook Inc.</u>	<u>1217 St. Paul St.</u>	

290 636

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *42*

1. PLACE OF DEATH COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>5528 Link Ave Md</i> COUNTY <i>Balto</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus</i>	
TOWN <i>Arbutus</i>		TOWN <i>Arbutus</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>5528 Link Ave</i>		STREET ADDRESS (If rural give location) <i>5528 Link Ave</i>	
3. NAME OF DECEASED (First) <i>JULIANNA</i> (Middle) <i>GOETZ</i> (Last) <i>GOETZ</i>		4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>4</i> (Year) <i>1951</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>July 23, 1919</i>
9. AGE last birthday <i>71</i> yrs.		10. BIRTHPLACE (State or foreign country) <i>Austria, Hungary</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Stephen Popelush</i>		14. MOTHER'S MAIDEN NAME <i>Francis Popelush</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY No. <i>no</i>	
17. INFORMANT <i>Mr. Julia Goetz - daughter</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Cerebral hemorrhage*

Antecedent cause(s)

(b) *Hypertension*

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. *none*

19a. DATE OF OPERATION <i>none</i>		19b. MAJOR FINDINGS OF OPERATION <i>none</i>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>none</i>		PLACE (Home, farm, factory, street, office bldg., etc.) <i>none</i>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>none</i>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <i>none</i>	

22. I hereby certify that I attended the deceased from *19 Jan*, 19*48*, to *4 Jan*, 19*51*, that I last saw the deceased

alive on *4 Jan*, 19*51*, and that death occurred at *1:20 P*.m., from the causes and on the date stated above.

SIGNATURE *William Goodman, M.D.* (Degree or title) ADDRESS *1334 Hudson Spring Rd* DATE SIGNED *4 Jan 51*

23. FUNERAL CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>1-8-51</i>		NAME OF CEMETERY OR CREMATORY <i>Holy Cross</i>		LOCATION (City, town, or county) (State) <i>A.A. Co Md</i>	
DATE REC'D BY LOCAL REG. <i>1/5/51</i>		REGISTRAR'S SIGNATURE <i>G. W. Hedrick</i>		24. FUNERAL DIRECTOR <i>W. B. Walters</i>		PREPARET <i>John</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shewood Road</u>		STREET ADDRESS (If rural, give location) <u>Shewood Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u> (Middle) <u>Thomas</u> (Last) <u>Guffith</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan</u> <u>5</u> <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 21 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Mail Carrier</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md</u>	
13. FATHER'S NAME <u>Abram Guffith</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Bent</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT AND ADDRESS <u>Mrs. Thos. B. Guffith Cockeysville, Md</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Carcinomatosis</u>	<u>3 yrs.</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Primary Carcinoma Prostate</u>	<u>6 yrs.</u>
	(c) <u>Arteriosclerotic Heart Disease</u>	<u>?</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>1944</u>	19b. MAJOR FINDINGS OF OPERATION <u>Prostatectomy for Carcinoma</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug., 1938, to 1-5-, 1957, that I last saw the deceased alive on 1-4-, 1957, and that death occurred at 3 A. m., from the causes and on the date stated above.

SIGNATURE Robert H. Live (Degree or title) M.D. ADDRESS 3105 N. Charles St. Balto. 18. Md. DATE SIGNED 1-7-57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE WHEREOF <u>1-7-57</u>	NAME OF CEMETERY OR CREMATORY <u>Boileys</u>	LOCATION (City, town, or county) (State) <u>Sparks, Maryland</u>
DATE REC'D BY LOCAL REG. <u>1-7-57</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Whitcomb</u>	24. FUNERAL DIRECTOR <u>Samuel M. Brooks, Sparks, Md</u>	ADDRESS <u>335 906</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Office
Mr. Siver Hoplun 4246

Residence
Hoplun 2749
3203 Albee Ave.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0207 41

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Stoneleigh</u> LENGTH OF STAY (in this place) <u>6 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armacost Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>314 S Newkirk St. (24)</u> ✓	
3. NAME OF DECEASED (Type or Print)	(First) <u>Missouri</u> (Middle) <u>(NMI)</u> (Last) <u>Grose</u>	4. DATE OF DEATH	(Month) <u>1</u> (Day) <u>30</u> (Year) <u>1951</u>
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10/28/1862</u>
9. AGE last birthday <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Washington M. Grose</u>	
14. MOTHER'S MAIDEN NAME <u>Vizelee Neil</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT <u>Sherman T. Grose (Son)</u>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
492x Immediate cause (a) <u>Pneumonia - Atypical</u>	<u>6 days</u>
109 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 24, 1951, to Jan 29, 1951, that I last saw the deceased alive on Jan 29, 1951, and that death occurred at 12:30 P. m., from the causes and on the date stated above.

SIGNATURE John L. Green Jr. M.D. ADDRESS W. L. Lawson - Md. DATE SIGNED 1/30/51

23. BURIAL, CREMATION REMOVAL	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2/1/51</u>	<u>Oak Lawn</u>	<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS	
<u>Jan 31-1951</u>	<u>William M. Kelly Jr.</u>	<u>Walter Brooks Bradley</u>	<u>Dundalk, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>701 Chapel Gate Lane</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GEORGE</u> (Middle) <u>A.</u> (Last) <u>HANSEN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 2 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-6-99</u>
9. AGE last birthday <u>51</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baltimore Sun Paper (Rural Route Mgr.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John L. Hanssen</u>		14. MOTHER'S MAIDEN NAME <u>Georgia E. Fout</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>213-03-2442</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CARCINOMA OF LIVER

INTERVAL BETWEEN ONSET AND DEATH

2 years

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec. 23, 1950, to Jan. 2, 1951, that I last saw the deceased live on Dec. 23, 1950 and that death occurred at 10:25 A.M. on the date stated above.SIGNATURE MERLE S. SCHERR, M.D. (Degree or title) VAH, FORT HOWARD, MARYLAND ADDRESS 1-2-51 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-5-51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG. <u>1/2/51</u>	REGISTRAR'S SIGNATURE <u>Wm. Tickner & Sons</u>	24. FUNERAL DIRECTOR ADDRESS <u>North & Pa. Avenues Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0209

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore 24	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 253 S. East Avenue	
3. NAME OF DECEASED (Type or Print) (First) LAWRENCE (Middle) J. (Last) HARTMAN		4. DATE OF DEATH (Month) January (Day) 11 (Year) 19 51	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 3-7-95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P. O. Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hartman		14. MOTHER'S MAIDEN NAME Katie Rinecker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

410x Immediate cause (a) MITRAL STENOSIS	INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
925 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) RHEUMATIC HEART DISEASE	UNKNOWN
(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 19 50, to Jan. 11, 19 51, that I last saw the deceased

live on 11-11-51, and that death occurred at 1:30 A. M., from the causes and on the date stated above.

SIGNATURE Paul Padgett (Degree or title) ADDRESS DATE SIGNED 1-11-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1-15-51	NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	LOCATION (City, town, or county) Baltimore, Maryland (State)
DATE REC'D BY LOCAL REG. 1-12-51	REGISTRAR'S SIGNATURE A. W. Hedrich	24. FUNERAL DIRECTOR Clarence F. Hoffmann	ADDRESS 1639 N. Broadway, Baltimore, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

6210

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PIKESVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>101 Reisterstown Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>WILBUR</u>	(Middle) <u>JAMES</u>	(Last) <u>HASTINGS SR.</u>
4. DATE OF DEATH	(Month) <u>JANUARY</u>	(Day) <u>12</u>	(Year) <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>11/2/1909</u>
9. AGE last birthday <u>43</u> yrs.	If under 1 year Months	If under 24 hrs Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cal. Prod.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electricity Cal. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Saunderbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harry Hastings</u>		14. MOTHER'S MAIDEN NAME <u>Lola Belle Krause</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY No. <u>217-03-4443</u>	
17. INFORMANT AND ADDRESS <u>Luise L. Hastings, 101 Reisterstown Pikeville, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>CORONARY THROMBOSIS</u>			<u>30 MIN.</u>
Antecedent cause(s) (b) <u>ARTERIOCLEROTIC CV. DISEASE</u>			<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE) <u>PIKESVILLE</u> <u>BALTIMORE</u> <u>MD.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE		ADDRESS	
<u>Martin E. Strobel</u>		<u>M.D. Reisterstown, Md.</u>	
DATE SIGNED <u>1/12/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/16/51</u>	<u>Baltimore National</u>	<u>Fredrick Ref. Balto. Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>1/25/51</u>	<u>D.W. Hedrick</u>	<u>Frank H. Yurell, Pikesville, Md.</u>	

682536

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

4903 Stafford
6 PM
Horwood Gardens

1. PLACE OF DEATH- COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
TOWN CATONSVILLE		TOWN CATONSVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 339 GREENLOW RD.		STREET ADDRESS (If rural, give location) 339 GREENLOW RD.	
3. NAME OF DECEASED (First) (Middle) (Last) MARGARET HAULPLIPE		4. DATE OF DEATH (Month) (Day) (Year) Jan. 11 1951	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH March 11, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD'S NURSE-RET.		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE	9. AGE last birthday 81 yrs.
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Haulplipe		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. ---	
17. INFORMANT AND ADDRESS MRS. MARGARET MEYER. 339 GREENLOW RD.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
332x Immediate cause (a)	Cerebral Thrombosis		2 weeks
83b Antecedent cause(s) (b)	Generalized Arteriosclerosis		unknown
(c)	Arteritis, rheumatoid		unknown
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY				

22. I hereby certify that I attended the deceased from **December 10, 1950**, to **January 11, 1951**, that I last saw the deceased alive on **January 10, 1951**, and that death occurred at **2:00 A.M.**, from the causes and on the date stated above.

SIGNATURE **James J. Urban MD** ADDRESS **5804 Edmondson Ave., Baltimore 28 MD** DATE SIGNED **Jan 12, 1951**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1-13-51	Holy Redeemer	Balto.	MD.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
1-13-51	T. E. Harry	George D. F. W. - Catonsville, Md.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

720 826



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

0212

1. PLACE OF DEATH:

County BaltimoreCity or town Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore City or town Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sister Mary Flavia Helfrich

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FemaleWhiteSingle

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Mar. 16, 18638. AGE: Years Months Days If less than one day
87 9 29 hrs. min.9. Birthplace Rochester N.Y.
(Town, county and state)10. Usual occupation Teacher11. Industry or business Belgium12. Name John Adam Helfrich13. Birthplace Germany14. Maiden name Marian Kimmel15. Birthplace Bavaria16. Informant Sr. Mary ClaraAddress Notch Cliff17. BURIAL Date thereof 1-17-51
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory NOTCH CLIFF CEM.Location NOTCH CLIFF NR TOWSON18. Funeral director Charles S. SeilerAddress 901 S. Conkling St. Balto 24th19. 1/16 19 51
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 19 51 at 6.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 29 19 39 to Jan 15 19 51and that I last saw him alive on Jan 9 19 51Immediate cause of death Pneumonia (Atypical)

DURATION

10 days

Due to

Due to

Other conditions

492x
109
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

SIGNATURE

Address Towson, Md. Date signed 1/15/51

078046

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. *42*

0213

1. PLACE OF DEATH- COUNTY <i>Balto</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Md</i> COUNTY <i>Balto</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Abtuta</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Abtuta Baltz</i>	
TOWN <i>Abtuta</i>		TOWN <i>Abtuta</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1107 Elm Ridge av</i>		STREET ADDRESS (If rural give location) <i>1107 Elm Ridge av</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>Charles</i> (Middle) <i>Clifton</i> (Last) <i>Hobbs</i>		4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>22</i> (Year) <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Widowed</i>	8. DATE OF BIRTH <i>6-7-1879</i>
9. AGE last birthday <i>71</i> yrs.		10. CITIZEN OF WHAT COUNTRY? <i>US</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Shas Hobbs</i>		14. MOTHER'S MAIDEN NAME <i>Langmann Hobbs</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>no</i>	
17. INFORMANT <i>Ida May Hobbs</i>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Coronary heart disease</i> Antecedent cause(s) (b) <i>420.1</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>94 a</i> (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>Dr. M. Keffer</i>		DATE SIGNED <i>1-22-57</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>1-25-57</i>	
NAME OF CEMETERY OR CREMATORY <i>Springfield</i>		LOCATION (City, town, or county) (State) <i>Springfield Md</i>	
DATE REC'D BY LOCAL REG. <i>Jan 25 1957</i>		REGISTRAR'S SIGNATURE <i>Dr. Keffer</i>	
24. FUNERAL DIRECTOR <i>C. M. Mally</i>		ADDRESS <i>681506</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0214
Reg. Dist. No. 33

1. PLACE OF DEATH— COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Maryland</u> <u>Baltimore</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glyndon</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glyndon</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Waugh Ave.</u>		STREET ADDRESS (If rural, give location) <u>Waugh Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Mary</u>	<u>Ransom</u>	<u>Holley</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 7, 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>43</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Downs, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Willard H. Ransom</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT <u>C. Brooks Holley, Glyndon, Md.</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
153x Immediate cause (a) <u>metastatic Carcinoma to Brain.</u>	<u>2 wks.</u>
462 Antecedent cause(s) (b) <u>Carcinoma of Sigmoid.</u>	<u>4 yrs.</u>
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>None</u>
19a. DATE OF OPERATION <u>July '48</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Sigmoid</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>None</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> . m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>None</u>

22. I hereby certify that I attended the deceased from 10-29, 1950., to 1-30, 1951., that I last saw the deceased alive on 1-27, 1951., and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE <u>D. D. Caples</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Reisterstown, Md.</u>	DATE SIGNED <u>2-1-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 1, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>All-Saints</u>	LOCATION (City, town, or county) (State) <u>Reisterstown, Md.</u>
DATE REC'D BY LOCAL REG <u>2-1-51</u>	REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>	24. FUNERAL DIRECTOR <u>J. F. Eline & Sons, Reisterstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>109 Henrietta Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>WILLIAM</u>	(Middle) <u>M</u>	(Last) <u>HOLMES</u>
4. DATE OF DEATH	(Month) <u>January</u>	(Day) <u>7</u>	(Year) <u>19 51</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married-Sep.</u>	8. DATE OF BIRTH <u>11-28-96</u>
9. AGE last birthday <u>54</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Middlesex Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Holmes</u>		14. MOTHER'S MAIDEN NAME <u>Vina Curtis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY No. <u>711-07-5592</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) ARTERIOSCLEROSIS OF RIGHT MIDDLE CEREBRAL ARTERY AND LEFT INFERIOR POSTERIOR CEREBELIAR ARTERY

Antecedent cause(s)

(b) WITH COMPLETE OCCLUSION AND INFARCTS OF BRAIN

UNKNOWN

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept. 20, 19 50, to Jan. 7, 19 51, that last saw the deceasedand that death occurred at 2:05 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 1-8-51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-12-51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/11/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Howard</u>	24. FUNERAL DIRECTOR <u>Mrs. Katie R. Williams</u>	ADDRESS <u>322 N. Schroeder St. Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **38**

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Towson		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Sheppard & Enoch Pratt Hosp.		STREET ADDRESS (If rural, give location) 2001 Park Avenue	
3. NAME OF DECEASED (Type or Print) Gertrude (First) (Middle) (Last) Holt		4. DATE OF DEATH 1 17 1951 (Month) (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 5, 1875 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Chalkley Holt		14. MOTHER'S MAIDEN NAME Rachel Shannon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS HOSPITAL RECORDS			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
334x Immediate cause (a) Pulmonary Hemorrhage		Terminal	
97 Antecedent cause(s) (b) Generalized arteriosclerosis		3 yr +	
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with Cerebral Arteriosclerosis		3 yr +	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug 20, 1948 , to Jan 17, 1951 , that I last saw the deceased alive on Jan 17, 1951 , and that death occurred at 12:45 m., from the causes and on the date stated above.			
SIGNATURE M. Elgin, M.D.		DATE SIGNED 1/17/51	
THE SHEPPARD & ENOCH PRATT HOSPITAL		ADDRESS Towson - 4, Md	
23. BURIAL, CREMATION REMOVAL (Specify) Funeral	DATE THEREOF 1-19-51	NAME OF CEMETERY OR CREMATORY Graceland Cemetery	LOCATION (City, town, or county) Balto. Md. (State)
DATE REC'D BY LOCAL REG 1/18/51	REGISTRAR'S SIGNATURE R. W. Redzel	2. FUNERAL DIRECTOR Stewart Mowenfo. Balto.	ADDRESS 107 W. ...

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0217

1. PLACE OF DEATH- COUNTY <u>BALTO</u> (MARYLAND)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO CO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO CO</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1401. Homberg Ave</u>		STREET ADDRESS (If rural give location) <u>1401. Homberg Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ANTON</u>	(Middle) <u>Homberg</u>	(Last) <u>Homberg</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>July 3, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Farm</u>	9. AGE last birthday <u>75</u> yrs. If under 1 year Months Days Hours Min.
13. FATHER'S NAME <u>Henry Homberg</u>		14. MOTHER'S MAIDEN NAME <u>Laura Goetze</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-07-8541</u>	
17. INFORMANT <u>Mrs. Jeanette Sassard</u>		1401. Homberg Ave	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Bundle Branch Block</u>	<u>2 yrs</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>arteriosclerotic Heart Disease</u>	<u>unknown</u>
	(c) <u>Carcinoma</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of Stomach</u>		<u>2 yrs</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1945, to Jan 23, 1951, that I last saw the deceased alive on Jan 2, 1951, and that death occurred at 5:40 P m., from the causes and on the date stated above.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/27-1951</u>	<u>Zion Lutheran - Cem</u>	<u>BALTO CO MD</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan 26, 1951</u>	<u>audedrich</u>	<u>Lorraine Funeral Home</u>	<u>7401 Belair Rd</u>	

335906

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Sh. Miceli

422 Eastern Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mount Wilson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mount Wilson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>		STREET ADDRESS (If rural, give location) <u>Mt. Wilson State Hospital</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Roy</u>	(Middle) <u>E.</u>	(Last) <u>Housholder</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12/24/1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kitchen Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>65</u> yrs. <u>0</u> Months <u>13</u> Days
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Roy E. Housholder, Mt. Wilson, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>Immediate cause</u> <u>Carcinoma of the Lung</u>		<u>3 or 4 yr</u>
(b) <u>Antecedent cause(s)</u> <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>No operation</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/22, 1950, to 1/15, 1951, that I last saw the deceased alive on 1/15, 1951, and that death occurred at 5:35 A.m., from the causes and on the date stated above.

SIGNATURE <u>Elmer P. Sauer</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Mt. Wilson, Maryland</u>	DATE SIGNED <u>1/15/51</u>
23. BURIAL, CREMATION, REBURY (Specify) <u>Cremation</u>	DATE THEREOF <u>1/17/51</u>	NAME OF CEMETERY OR CREMATORY <u>Louden Park</u>	LOCATION (City, town, or county) (State) <u>Fred. Rd., Balto., Md.</u>
DATE REC'D BY LOCAL REG. <u>1/15/51</u>	REGISTRAR'S SIGNATURE <u>John R. Mayer</u>	24. FUNERAL DIRECTOR <u>Frank Newell, Pikesville, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7620826



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in #8 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0219

CERTIFICATE OF DEATH

Reg. Dist. No.

Form No. G 1-6 JAN 25 1951

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> TOWN <u>Essex</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> TOWN <u>Essex</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>107 Riverside Rd.</u>		STREET ADDRESS (If rural, give location) <u>107 Riverside Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JAMES</u> (Middle) <u>WESLEY</u> (Last) <u>HUGHES</u>	4. DATE OF DEATH	(Month) <u>1</u> (Day) <u>17</u> (Year) <u>1951</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11/31/64</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Special Police</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co.</u>	9. AGE last birthday <u>86</u> yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Louise Wood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>40-2</u>	
17. INFORMANT AND ADDRESS <u>Mrs. W. W. Hughes 107 Riverside Rd.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause (a)	<u>Pulmonary edema</u>		<u>1 day</u>
93d Antecedent cause(s) (b)	<u>Hypertensive C-V disease</u>		<u>10 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 19, 46 to Jan 17, 1951, that I last saw the deceased alive on Jan 17, 1951, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/20/51</u>	<u>Oak Lawn</u>	<u>Balto. Co.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1/19/51</u>	<u>HW Hedrick</u>	<u>Lanahan Funeral Home</u>	<u>7401 Bglair</u>

773936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of age shown on: is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

0220

CERTIFICATE OF DEATH

FILM No. G 130 JAN 16 1951 FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) Carney HOSPITAL OR INSTITUTION OR STREET ADDRESS 7 Fuller Avenue		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Baltimore COUNTY Maryland CITY (If outside corporate limits, write RURAL and give nearest town) Carney STREET ADDRESS (If rural give location) 7 Fuller Avenue	
3. NAME OF DECEASED (Type or Print) GOTTLEIB (First) JOHN (Middle) HUTSCHENREUTER (Last)		4. DATE OF DEATH Month Jan (Day) 8 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 15, 1902
9. AGE last birthday 47 yrs.		10. If under 1 year Months 8 Days 8 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing Contractor		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Hutschenreuter		14. MOTHER'S MAIDEN NAME Anna Blei	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Marie Hutschenreuter, Carney, Md.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause Asphyxiation hanging: Suicide		Sudden	
(b) Antecedent cause(s) Melancholia Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		2 yrs +	
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE Rollin C. Hudson M.D.		DATE SIGNED 1/10/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		NAME OF CEMETERY OR CREMATORY Zion Lutheran Cemetery	
DATE REC'D BY LOCAL REG. 1/11/51		LOCATION (City, town, or county) Stemmers Run, Maryland	
REGISTRAR'S SIGNATURE A. W. Hudson		24. FUNERAL DIRECTOR Joan Burnas' Sons, Towson, Maryland	

STV

581246

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0221 32

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Villa Nova		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Katherine Robb Nursing Home		STREET ADDRESS (If rural, give location) 5 N. Kossuth Street	
3. NAME OF DECEASED (First) Eva Marie (Middle) Hyde (Last)		4. DATE OF DEATH (Month) Jan. (Day) 28, (Year) 1951	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct. 20, 1892 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 58 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Fred Beck		14. MOTHER'S MAIDEN NAME Anna Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS Clinton M. Hyde, 884 Benninghaus Road	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Cerebral Hemorrhage		
Antecedent cause(s) (b) Arterial by Arteriosclerosis		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Cerebral Hemorrhage		1947
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Myocarditis		?
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1-28-**, 19**47**, to **1-28**, 19**51**, that I last saw the deceased alive on **1-28**, 19**51**, and that death occurred at **2:10** m., from the causes and on the date stated above.

SIGNATURE Dr E E Nichols		ADDRESS Pikesville 8 Md		DATE SIGNED 1-29-51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1/31/51	NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	LOCATION (City, town, or county) Pikesville, Maryland	(State)
DATE REC'D BY LOCAL REG. 1-29-51	REGISTRAR'S SIGNATURE Dr E E Nichols	24. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street		ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
FEB 5 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0222 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 14</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>5215 Tramore Road,</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>NORMAN S. IGLEHART</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 8, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widower</u>	8. DATE OF BIRTH <u>Jan. 17, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil & Gasoline distributors</u>	9. AGE last birthday <u>77</u> yrs. <u>11</u> Months <u>22</u> Days
11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Emery Iglehart</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Emmert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Hospital Record, Catonsville 28, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) cardio-respiratory failure

INTERVAL BETWEEN ONSET AND DEATH

5 min.

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertrophy and dilatation of the heart with mitral insufficiencyUnknown(c) Generalized arterio-sclerotic cardio-vascular dis.Unknown

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec. 20, 1950, to Jan. 8, 1951, that I last saw the deceasedalive on Jan. 8, 1951, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE TIME OF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/12/51</u>	<u>Moreland Mem. Pk.</u>	<u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/9/51</u>	<u>A. W. Hedrick</u>	<u>Wm. J. Tichner & Sons - Balto</u>	<u>Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *30*

1. PLACE OF DEATH: COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Catonsville Md.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Spring Grove St. Hosp.</i>		STREET ADDRESS (If rural, give location) <i>1022 Warden St.</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>SALVATORE</i> (Middle) (Last) <i>ILLARI</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Jan. 6 1951</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>5-5-1885</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Agent</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	9. AGE (last birthday) (If under 1 year) (If under 24 hrs.) <i>65 yrs.</i> Months Days Hours Mio.
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY No. <i>395-09-5443</i>	
17. INFORMANT AND ADDRESS <i>Hospital Records</i>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Pulmonary Embolus</i>			<i>5 min</i>
Antecedent cause(s) (b) <i>Cellulitis of Genitalia and thighs</i>			<i>2 mo.</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>C.V.S. Les. E bladder atony</i>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *12-19*, 19*50*, to *1-6*, 19*51*, that I last saw the deceased alive on *1-5*, 19*51*, and that death occurred at *9:35 A.M.*, from the causes and on the date stated above.

SIGNATURE <i>Florence Derringer Joyce</i>		ADDRESS <i>Spring Grove St. Hosp.</i>	
23. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>Jan. 9 1951</i>	NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Park</i>	LOCATION (City, town, or county) (State) <i>Taylor Ave Baltimore Md.</i>
DATE REC'D BY LOCAL REG. <i>1/8/51</i>	REGISTRAR'S SIGNATURE <i>A. W. Haden</i>	24. FUNERAL DIRECTOR <i>Fraule Della Woe 322 S HIGH ST.</i>	

450736

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

0224

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Middle River</u>	
TOWN <u>Catonsville</u>		TOWN <u>Baltimore</u> <u>Middle River</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>(Seton Institute)</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ROBERT</u> <u>L.</u> <u>JENKINS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 10,</u> <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 3, 1883</u>
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Thomas Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Bartler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records, Catonsville 28, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cachexia</u>			<u>3 months</u>
Antecedent cause(s) (b) <u>Carcinoma of the large bowel</u>			<u>2 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 1, 1950, to Jan. 10, 1951, that I last saw the deceased alive on Jan. 10, 1951, and that death occurred at 11:55 p.m., from the causes and on the date stated above.

SIGNATURE Flora Deringer Joyce ADDRESS Spring Grove State Hospital DATE SIGNED 1/11/51
(Degree or title) M. D. Catonsville 28, Maryland

23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	DATE <u>Jan. 13, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Orems Meth. Cemetery</u>	LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u>
DATE REC'D BY LOCAL REG. <u>1/12/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Lassburn Funeral Home</u>	ADDRESS <u>7401 Belair Rd.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

970/116

Former residence obtained by phone from the Seton Institute - 2-8-51 - ams.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0225

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>114 Burke Avenue</u>		STREET ADDRESS (If rural, give location) <u>114 Burke Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charlotte</u> (Middle) <u>C.</u> (Last) <u>Jessop</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 9, 1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>March 4, 1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>89</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Jolly</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mays</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>--</u>	
17. INFORMANT AND ADDRESS <u>Jennie E. Jessop, 114 Burke Avenue</u>			

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Atherosclerosis Cerebral</u>			
Antecedent cause(s) <u>334 X 97</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>19 Jan 9 1951</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 Jan 9</u> , 19 <u>51</u> , to <u>19 Jan 9</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>19 Jan 9</u> , 19 <u>51</u> , and that death occurred at <u>11 E. Chase St., Baltimore 2, Md.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Louis Krause</u>		ADDRESS <u>11 E. Chase St., Baltimore 2, Md.</u>	
DATE SIGNED <u>1-12-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>1/13/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Jessop M. E. Cemetery</u>		LOCATION (City, town, or county) <u>Cockeysville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 102645

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 20, Maryland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 20, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>38 Back River Neck Rd.,</u>		STREET ADDRESS (If rural, give location) <u>38 Back River Neck Rd.,</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edward</u> (Middle) <u>Jordan</u> (Last) <u>Jordan</u>	4. DATE OF DEATH (Month) <u>January</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 2, 1880</u>
9. AGE last birthday <u>70</u> yrs.		10. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
11. BIRTHPLACE (State or foreign country) <u>Back River Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Thomas Jordan</u>		14. MOTHER'S MAIDEN NAME <u>Alveta Jordan</u>	
15. SOCIAL SECURITY NO.		16. INFORMATION AND ADDRESS <u>Alveta Jordan Back River Neck Road</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443x Immediate cause 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(a) <u>Cerebral Hemorrhage, left Hemisphere</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 yrs.</u>
	(b) <u>Hypertensive Cardiovascular disease</u>	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1950, to Jan 30, 1951, that I last saw the deceased alive on Jan 30, 1951, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

SIGNATURE Joseph Shear (Degree or title) MD. ADDRESS 805 Franklin Ave DATE SIGNED 1/30/51

23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>		<u>St. Stephens Cemetery</u>	<u>Essex</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>2/2/51</u>	<u>D.W. Ndlich</u>	<u>Mrs. Ruth A. Elliott & Daughter</u> <u>970 VV 1129 N. Caroline St.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *30*

1. PLACE OF DEATH COUNTY <i>BALTO</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MD</i> COUNTY <i>BALTO</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>✓</i>		STREET ADDRESS (If rural give location) <i>314 SHADY NOOK AVE</i>	
3. NAME OF DECEASED (Type or Print) <i>CHARLES A KASTEN</i>		4. DATE OF DEATH <i>1-26-51</i>	
5. SEX <i>M.</i>	6. COLOR OF RACE <i>WHT</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>FEB 26 1884</i>
9. AGE last birthday <i>66</i> yrs.		10. If under 1 year: Months <i>11</i> Days <i>11</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>OWNER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>POULTRY</i>	
11. BIRTHPLACE (State or foreign country) <i>GERMANY</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>NOT KNOWN</i>		14. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>✓</i>		16. SOCIAL SECURITY No. <i>✓</i>	
17. INFORMANT <i>MRS DORA KASTE SHADY NOOK AVE</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <i>Carcinoma of recto-sigmoid</i>		
Antecedent cause(s) (b) <i>154X 46d</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <i>May 31, 1949</i>	19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of recto sigmoid</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May 31, 1949*, to *Jan 26, 1951*, that I last saw the deceased alive on *Jan 25, 1951*, and that death occurred at *2 P* m., from the causes and on the date stated above.

SIGNATURE <i>John H. Barnaby, MD</i>		ADDRESS <i>1531 E North Ave</i>		DATE SIGNED <i>Jan 26, 1951</i>	
23. BURIAL, CREMATION, or other disposal (Specify)	DATE OF THEOP <i>1/31/51</i>	NAME OF CEMETERY OR CREMATORY <i>LORRAINE PK</i>	LOCATION (City, town, or county) <i>DICKETTSVILLE MD</i>	(State)	
DATE REC'D BY LOCAL REG. <i>1/29/51</i>	REGISTRAR'S SIGNATURE <i>Dr. Redick</i>	FUNERAL DIRECTOR <i>Elott H. Reinbach</i>		ADDRESS <i>100105</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0228

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Hyde</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Hyde</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Long green</u>		STREET ADDRESS (If rural, give location) <u>Long green, Hyde Md.</u>	
3. NAME OF DECEASED (First) <u>SARAH</u> (Middle) <u>E</u> (Last) <u>Kelly</u>		4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 13 - 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		11b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Thomas Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Mary HANLON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr. Jos. M. Kelly - Long green, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

21 hrs.

Antecedent cause(s)

(b)

General Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Arteriosclerotic heart disease

4 yrs.

Diabetes Mellitus

7 yrs.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1945, to Jan. 16, 1951, that I last saw the deceased

alive on Jan 15, 1951, and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial

1/19/51

St. John's Cem

Long green, Md.

4/18/51

Wm. H. H. H.

Leonard J. Ruck 5305 Hartford Rd

MARGIN RESERVED FOR BINDING

VS-A15

Dr. Hudson.
Fork, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>717 Linda Drive</u>		STREET ADDRESS <u>717 Linda Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ALBERT</u> (Middle) <u>EDWARD</u> (Last) <u>KILNER</u>	4. DATE OF DEATH (Month) <u>January</u> (Day) <u>13th.</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>3/29/71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist (employed)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>	9. AGE last birthday <u>79</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Isaac Kilner</u>		14. MOTHER'S MAIDEN NAME <u>Harriett (unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Eugene Murphy 717 Linda Drive Catons.</u>		Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

1 wtc

10 yrs.

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 6, 1950, to Jan 13, 1951, that I last saw the deceased

alive on Jan 13, 1951, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-16-51

V.E. Harry

Easton Sons Catonsville, Md.

073669

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

435



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 113311 XX

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ft. Howard</u> TOWN <u>Ft. Howard</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 24</u> STREET ADDRESS (If rural, give location) <u>102 South Dean Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Andrew J. KIST</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-1-91</u>
9. AGE last birthday <u>59</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mach. Helper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>P.R.R.</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Kist</u>	
14. MOTHER'S MAIDEN NAME <u>Ma rie Schiloker</u>		15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWKI</u>	
16. SOCIAL SECURITY No. <u>unknown 7-7024</u>		17. INFORMANT AND ADDRESS <u>Clin. Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) MYELOID LEUKEMIA

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

Unknown

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov. 9, 1950, to Jan. 1, 1951, that I last saw the deceased

alive on 1-15, 1951, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

DAVID H. KUNTZ, M.D.

1-1-51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan. 4, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>1/3/51</u>		REGISTRAR'S SIGNATURE <u>How Reduel</u>		24. FUNERAL DIRECTOR <u>John Connelly</u>		ADDRESS <u>418 Eastern Ave. Balto. 21 Md.</u>	

MARGIN RESERVED FOR BINDING

I

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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1010 02312

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Grey Manor</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Grey Manor</u>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>2907 Page Drive</u>		STREET ADDRESS (If rural, give location) <u>2907 Page Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>VIOLET</u>	(Middle) <u>M.</u>	(Last) <u>KNIGHTON</u>
4. DATE OF DEATH	(Month) <u>Jan.</u>	(Day) <u>3,</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 9, 1872</u>
9. AGE last birthday <u>78 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James St. John</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>1010 North Paul Rd</u>	
17. INFORMANT AND ADDRESS <u>John A. Knighton, 1509 N. Rose St.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Pulmonary Oedema</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Antecedent cause(s) (b) <u>Coronary Thrombosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	<u>3 days</u>
(c) <u>Diabetes Mellitus</u>	<u>15 years</u>

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Hypertension Arterio-sclerosis</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1950, to Jan 3, 1951, that I last saw the deceased alive on Jan 2, 1951, and that death occurred at 2 a.m., from the causes and on the date stated above.

SIGNATURE M. A. Jacob (Degree or title) M.D. ADDRESS 1010 North Paul Rd DATE SIGNED 1/3/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>1/6/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE REC'D BY LOCAL REG. <u>1/4/51</u>	REGISTRAR'S SIGNATURE <u>Redneck</u>	24. FUNERAL DIRECTOR <u>Monroe</u>	ADDRESS <u>1214 St Paul St</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0232

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 1904 Chelsea Road	
3. NAME OF DECEASED (First) FRANK (Middle) J. (Last) KRAMER		4. DATE OF DEATH (Month) January (Day) 4 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 11-1-94
9. AGE (last birthday) 56 yrs.		10. AGE (last birthday) If under 1 year Months Days If under 24 hrs. Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11b. KIND OF BUSINESS OR INDUSTRY	
12. FATHER'S NAME Peter Kramer		13. MOTHER'S MAIDEN NAME Christinia Feller	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		15. SOCIAL SECURITY No. 215-14-0133	
16. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		17. CITIZEN OF WHAT COUNTRY? USA	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CARDIAC DILATATION AND HYPERTROPHY

INTERVAL BETWEEN ONSET AND DEATH

1 year +

Antecedent cause(s)

(b) None

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec. 27, 1950, to Jan. 4, 1951, and that death occurred at 2:20 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 1-5-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1-8-50	NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	LOCATION (City, town, or county) Baltimore, Md.	(State)
--	---------------------	--	---	---------

DATE REC'D BY LOCAL REG. January 6, 1951	REGISTRAR'S SIGNATURE R.W.	24. FEDERAL DIRECTOR William Cook	ADDRESS St. Paul and Prestons Sts. Baltimore, Maryland
--	----------------------------	-----------------------------------	--

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
TOWN <u>Dundalk</u>		TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1805 Maxwell Ave.</u>		STREET ADDRESS (If rural, give location) <u>1805 Maxwell Ave.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Peter Paul Krantz (Kaczorowski)</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 9 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 9 1898</u>
9. AGE last birthday <u>52</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Krantz (Kaczorowski)</u>		14. MOTHER'S MAIDEN NAME <u>Eleonore Welnicki</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
434.3 Immediate cause (a) <u>Cardiac insufficiency.</u>			
Antecedent cause(s) (b) <u>Seemingly acute nephritis.</u>			
130 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Immediate severe uraemia.</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>X</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>X</u> PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Dec. 15, 1950 to Jan. 9, 1951, that I last saw the deceased alive on Jan. 8, 1951, and that death occurred at 12:45 A.M. from the causes and on the date stated above.

SIGNATURE Allen C. Beetham, 3139 E. Balto. St. DATE SIGNED Jan. 10-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan 13/51</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cmn</u>	LOCATION (City, town, or county) (State) <u>Balto. County</u>
DATE REGD BY LOCAL REGISTRAR'S SIGNATURE <u>1/11/51</u>		24. FUNERAL DIRECTOR <u>A. W. Hedrick</u>	
		ADDRESS <u>John M. Weber 401 S. Chester Street</u>	
		<u>690 336 Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>2948 Edmondson Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LOUIS</u>	(Middle) <u>C.</u>	(Last) <u>KRATZENBERG</u>
4. DATE OF DEATH	(Month) <u>January</u>	(Day) <u>24</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>6-11-95</u>
9. AGE last birthday <u>55</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Rochester, New York</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Kratzenberg</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Beth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>213-10-5553</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) NOCARDIA ASTEROIDS INFECTIONS OF LUNGS 8TH AND 10TH RIBS, LEFT AND ABSCESS OF PARAVERTEBRAL MUSCLES

Unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 24, 1950, to Jan. 24, 1951, that I last saw the deceasedand that death occurred at 8:00 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

R. J. LIPIN, M. D., ACTING CHIEF, SURGICAL SERVICE, VAH, FORT HOWARD, MD. 1-24-51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

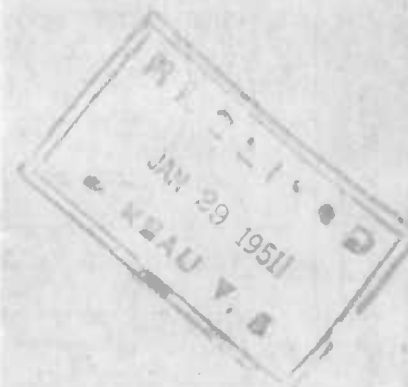
ADDRESS

Howard Blight Funeral Home 6009 Harford Rd., Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Baltimore
County.....
City or town..... Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, institution, or street address where death occurred:
2005 Alta Vista Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town..... Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2005 Alta Vista Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME CLARENCE RAYMOND KRIETE 3. (b) Social Security Number 212-03-4358

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Eva Harrison Kriete
6. (c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) July 6, 1884
8. AGE: Years 66 Months Days It less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Shirt Cutter
11. Industry or business Clothing
FATHER 12. Name Herman Kriete
13. Birthplace Germany
MOTHER 14. Maiden name Amelia
15. Birthplace Germany

16. Informant Clarence H. Kriete
Address Colonial Park, Baltimore, Md
17. Burial Burial Date thereof Jan. 8, 1951
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Lorraine Pk.
Location Woodlawn, Md.

18. Funeral director Harry H. Witzke
Address 4101 E. Edmondson Ave
19. January 6th 51 R.W.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH January 5, 1951 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1949 to January 5, 1951
and that I last saw him alive on January 4, 1951

Immediate cause of death Carcinoma of Stomach DURATION 1 yr.

Due to 1st X

Due to

Other conditions Pulmonary 2 yrs
466 Tuberculosis
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard T. Traub, M.D.
Address 3400 Woodbine Ave. Balt. Md. Date signed 1/5/51
690448

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 11

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Point</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>704 E. Street</u>		STREET ADDRESS (If rural, give location) <u>704 E. Street</u>	
3. NAME OF DECEASED (Type or Print) <u>DANIEL</u> (First) <u>LANE</u> (Middle) <u>LANE</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>January 1, 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>12-19-1896</u>
9. AGE last birthday <u>54</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick J. Lane</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Margaret White Sparrow's Point</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Fracture of neck</u>		
Antecedent cause(s) (b) <u>900.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> PLACE (Home, farm, factory, street, office hldg., etc.) <u>home</u>	(CITY OR TOWN) <u>Sparrows Point, Baltimore, Md.</u> (COUNTY) <u>Baltimore</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 1, 1951 12.15 a.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell down steps at home</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>B. Fisher</u> M.D. 700 Fleet St., Baltimore 2, Md. Jan. 1, 1950		DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-5-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Oaklawn</u>
LOCATION (City, town, or county) <u>Baltimore</u>	(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>1-3-51</u>	REGISTRAR'S SIGNATURE <u>John G. Moran</u>	24. FUNERAL DIRECTOR ADDRESS <u>3000 E. Baltimore St.</u>

585 376

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0237

Reg. Dist. No. 4-1

1. PLACE OF DEATH COUNTY BALTO.		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD. COUNTY BALTO	
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK		LENGTH OF STAY (in this place) 20 mo.		CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5 NORTHSHIP RD.				STREET ADDRESS (If rural, give location) 5 NORTHSHIP RD.	
3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle) BENJAMIN	(Last) LANHAM	4. DATE OF DEATH	(Month) JAN. (Day) 11 (Year) 1951
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 7/2/1858	9. AGE last birthday 92 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME W. B. LANHAM, SR.			14. MOTHER'S MAIDEN NAME MARY ELLEN HENRY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT WALTER L. MILLER	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) **INJURY**

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BURIAL **1/13/51** **OAK LAWN** **BALTO. CO. MD.**
Jan. 13-1951 **William M. Kelly J. Walter, Brother Bradley, Dundalk, Md.**

574337

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 15 1961
A. A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWNSHIP Towson		CITY (If outside corporate limits, write RURAL and give nearest town) TOWNSHIP Anneslie	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mercy Villa 6900 Bellona Ave		STREET ADDRESS (If rural, give location) 505 Murdock Road	
3. NAME OF DECEASED (Type or Print) Mary Elizabeth Lawrence		4. DATE OF DEATH (Month) Jan. (Day) 24 (Year) 19 51	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 9/29/83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE last birthday 67 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? ---	
13. FATHER'S NAME Nathaniel Moore		14. MOTHER'S MAIDEN NAME Alice Hopkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs. Jas. P. Warner 505 Murdock Road		---	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 3 years
Immediate cause (a) Arterio-sclerotic Cardio-Vascular disease		
422.1 Antecedent cause(s) (b) ---		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) ---		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1946, to 24 Jan, 1951, that I last saw the deceased alive on 24 Jan, 1951, and that death occurred at 11 A.M., from the causes and on the date stated above.

SIGNATURE Charles H. Reier M.D. ADDRESS 6701 York Rd Baltimore 12 Md DATE SIGNED 25 Jan 51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1/27/51	Loudon Park	Baltimore, Md.	---
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
1/26/51	A. W. Tedman	W. B. Means	205 7/1 Calver St	

51

MARGIN RESERVED FOR BINDER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0239 42

1. PLACE OF DEATH
 County Baltimore
 City or town Arbutus
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 yrs
 Hospital, institution, or street address where death occurred:
4313 Wilkens Ave
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Arbutus
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4313 Wilkens Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Frank M. Levering

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Minnie M.

7. Birth date of deceased (mo., day, yr.) 8/23/1885 8.(c) If alive, give age _____ years

8. AGE: Years 65 Months 4 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Stoboken, N.J.
 (Town, county, and state)

10. Usual occupation Tile setter

11. Industry or business For Self

12. Name Franklin M. Levering

13. Birthplace New Jersey

14. Maiden name Catherine M. Wheeler

15. Birthplace New Jersey

16. Informant Mrs Minnie M. Levering

Address 4313 Wilkens Ave

17. Burial Date thereof 1/9/51
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Christ's Cem.

Location 2930 Frederick Ave

18. Funeral director John J. Cowan & Son

Address 1901 Hollins St.

19. 1/8 19 51 A. W. Hansen
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6/ 19 51 at 4 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1- 19 50 to Jan 6 19 51
 and that I last saw him alive on Jan 5- 19 51

Immediate cause of death generalized toxemia DURATION 2 mo

Due to Carcinoma of Lung. 6 mo.

Due to 163X

Other conditions 47d

(Include pregnancy within 8 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Egbert H. Mortimer Jr M.D.

Address 2706 St Paul St Date signed 1/6/51

504246

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsvilles</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>536 S. 48th St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Caroline</u>	(Middle) <u>A.</u>	(Last) <u>Leyshon</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widow</u>	4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>30</u> (Year) <u>1951</u>
8. DATE OF BIRTH <u>June 19, 1881</u>		9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Maisch</u>		14. MOTHER'S MAIDEN NAME <u>Katherine H einrich</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>215-09-2891</u>	
17. INFORMANT AND ADDRESS <u>Mr. Wm. Ard 536 S. 48 th St. Bal</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442x Immediate cause
Antecedent cause(s)
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Uremia
(b) Hypertensive Cardio vascular renal dis.
(c)

INTERVAL BETWEEN ONSET AND DEATH

Unknown
Unknown

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 28, 1951, to Jan 30, 1951, that I last saw the deceased alive on Jan 29, 1951, and that death occurred at 6 30 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 1, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	LOCATION (City, town, or county) <u>Baltimore Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>2/1/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Henry Sander & Sons Inc.</u> <u>Baltimore Md</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0241

CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		LENGTH OF STAY (In this place) 13 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.				STREET ADDRESS (If rural, give location) 1832 Light Street		✓	
3. NAME OF DECEASED (Type or Print) WILBERT		(First)		(Middle) H.		(Last) LINTON	
4. DATE OF DEATH January 15		(Month)		(Day)		(Year) 1951	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 7-7-97	
9. AGE last birthday 53		yr.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Galvanizer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Linton		14. MOTHER'S MAIDEN NAME Ada Woodey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY No. Unknown		17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

162x Immediate cause (a) BRONCHOGENIC CARCINOMA, LEFT UPPER LOBE BRONCHUS
WITH METASTASES TO LIVER, ADRENALS, BRAIN
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause fast
47c (c)

UNKNOWN

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?							

22. I hereby certify that I attended the deceased from Jan. 2, 1951, to Jan. 15, 1951, that I last saw the deceased

alive on 1/12/51, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 1-15-51

23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1-18-1951		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) Baltimore, Maryland		(State)	
--	--	------------------------	--	--	--	--	--	---------	--

DATE REC'D BY LOCAL REG. 1/17/51		REGISTRAR'S SIGNATURE H. W. Hedrick		24. FUNERAL DIRECTOR Flynn & Fleming		ADDRESS 1426 Light Street		Baltimore, Maryland	
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>	
TOWN <u>Stoneleigh</u>		TOWN <u>Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armcast Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>----</u>	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>Mays</u> (Last) <u>Little</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>1</u> (Year) <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. ? 1876</u>
9. AGE last birthday <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Parkton, Balto. Co.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Atty. & President First Nat. Bk. Parkton</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Not obtainable</u>		14. MOTHER'S MAIDEN NAME <u>Not obtainable</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Elmer R. Haile Reckord Bldg., Towson</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>apoplexy</u>			
Antecedent cause(s) (b) <u>arterio-sclerosis hypertensive</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>---</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>---</u> PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>---</u> (CITY OR TOWN) <u>---</u> (COUNTY) <u>---</u> (STATE) <u>---</u>			
TIME (Month) (Day) (Year) (Hour) <u>---</u> INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>---</u>	
22. I hereby certify that I attended the deceased from <u>Dec. 24, 1950</u> , to <u>Jan. 1, 1951</u> , that I last saw the deceased alive on <u>Jan. 1, 1951</u> , and that death occurred at <u>8:15 P. M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>John F. Green</u> (Degree or title) <u>---</u> ADDRESS <u>---</u> DATE SIGNED <u>1/3/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>---</u> DATE <u>1/4/51</u> NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u> LOCATION (City, town, or county) <u>Pikesville</u> (State) <u>---</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>---</u>		24. FUNERAL DIRECTOR <u>W. W. Meeks and Son 805 N. Calvert St.</u> ADDRESS <u>---</u>	

055 716

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> 20 MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balti</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balti</u>	
TOWN <u>2 days</u>		TOWN <u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 Harrison Ave.</u>		STREET ADDRESS (If rural, give location) <u>519 Fairview Ave.</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>W.</u> (Last) <u>Ludwig</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept 19, 1887</u>
			9. AGE last birthday <u>63</u> yrs. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William G Ludwig</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Keys</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>717-07-6125</u>	
17. INFORMANT <u>Son John W. Ludwig</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary edema

181X
52b Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of bladder

(c)

INTERVAL BETWEEN ONSET AND DEATH

7 days

2 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Extreme weight loss & malnutrition

19a. DATE OF OPERATION <u>July 14, 50</u>	19b. MAJOR FINDINGS OF OPERATION <u>Ca. of Bladder</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1950, to Jan 3, 1951, that I last saw the deceased

alive on Jan 2, 1951, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

SIGNATURE Charles M. Kerr MD (Degree or title) ADDRESS 815 Eastern Ave Essex DATE SIGNED 3 Jan 51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>1/6/51</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	LOCATION (City, town, or county) <u>Balti Co</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/5/51</u>	REGISTRAR'S SIGNATURE <u>Dr. Redner</u>	24. FUNERAL DIRECTOR <u>Ullrich Funeral Home</u>	ADDRESS <u>2008 Chelms</u>	

510506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0244

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Daniels</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>106 Lower Brick Row</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Daniels</u> STREET ADDRESS (If rural, give location) <u>106 Lower Brick Row</u>	
3. NAME OF DECEASED (Type or Print) <u>Rose Marlow</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>1-16-51</u> (Month) (Day) (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1871</u> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>80</u> Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Webb Wiles, Daniels, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Malnutrition</u>		<u>1 month?</u>
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>		<u>10 yrs -</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Ramphigus</u>		<u>4 days -</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-15, 1951, to 1-16, 1951, that I last saw the deceased alive on 1-16, 1951, and that death occurred at 11 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-18-51</u>	NAME OF CEMETERY OR CREMATORY <u>Daniels</u>	LOCATION (City, town, or county) (State) <u>Daniels, Maryland</u>
DATE REC'D BY LOCAL REG. <u>1-17-51</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	24. FUNERAL DIRECTOR <u>F. C. Higinbotham</u>	ADDRESS <u>Ellicott City, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Grott

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0245

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Parkville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2725 Maple Avenue</u>		STREET ADDRESS (If rural, give location) <u>2725 Maple Avenue</u>	
3. NAME OF DECEASED (First) <u>George</u> (Middle) <u>A.</u> (Last) <u>Martin</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Mar. 12, 1874</u>
9. AGE last birthday <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Walter Martin</u>		14. MOTHER'S MAIDEN NAME <u>Lena ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Wills, 2725 Maple Avenue</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH
?

Immediate cause

(a) Carcinoma of head of pancreas

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 20, 1950, to Jan. 5, 1951, that I last saw the deceased alive on Jan. 3, 1951, and that death occurred at 3:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1/8/51A. W. HedrickLeonard J. Ruck5305 Harford Rd

JIV

534516

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0246 40

1. PLACE OF DEATH- 1704 Yakona Rd. COUNTY Baltimore County, MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baynesville HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Balto. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Baltimore STREET ADDRESS (If rural, give location) 1704 Yakona Rd.			
3. NAME OF DECEASED (Type or Print)		(First) John		(Middle) Kirby		(Last) MARTIN	
6. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 4-6-1885	
9. AGE last birthday 65 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Eng.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME John N. T. Martin				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 578-05-4918		17. INFORMANT AND ADDRESS Mrs. Jessie Martin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Uremia						4 yrs.	
Antecedent cause(s) (b) Carcinoma of prostate							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDE HOMICIDE				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July, 1950, to Jan 25, 1951, that I last saw the deceased alive on Jan 25, 1951, and that death occurred at 7:45 P.m., from the causes and on the date stated above.							
SIGNATURE Gordon Egan MD				ADDRESS 8523 Loch Raven Bldg		DATE SIGNED 1/26/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Jan. 29th		NAME OF CEMETERY OR CREMATORY Parkwood		LOCATION (City, town, or county) Balto. Co., Md. (State)	
DATE REC'D BY LOCAL REG. 1-26-51		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co., Inc. 4905 York Rd. Balto., 12, Md.			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr Ed Gordon Gray

8523 Loch Raven Blvd

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
of 21- shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

FILM No. G 150 FEB 14 1951

1. PLACE OF DEATH- COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY					
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore					
HOSPITAL OR INSTITUTION OR STREET ADDRESS Paradise Nursing Home		STREET ADDRESS 1906 Riggs Ave.					
3. NAME OF DECEASED (Type or Print) LOUISE E. MARTIN		4. DATE OF DEATH (Month) Jan. (Day) 31 (Year) 19 51					
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH March 2, 1865				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE last birthday 85 yrs. <table border="1"><tr><td>If under 1 year</td><td>If under 24 hrs.</td></tr><tr><td>Months</td><td>Days</td></tr></table>	If under 1 year	If under 24 hrs.	Months	Days
If under 1 year	If under 24 hrs.						
Months	Days						
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Ferdinand Siegmann		14. MOTHER'S MAIDEN NAME Dora Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none					
17. INFORMANT AND ADDRESS Mr. Ferdinand Siegman - 1705 De Soto Rd.							

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Arteriosclerotic Cardiovascular Disease**

INTERVAL BETWEEN ONSET AND DEATH

? years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Fracture hip, left.

4 mos

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE Accident		PLACE (Home, farm, factory, street, OF office bldg., etc.) Home		(CITY OR TOWN) 1806 Riggs Ave., Balto. 17, Md. (COUNTY) 17, Md. (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY 7-14-50 m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? Fell in hallway about 4.20 AM. (2-14-51)	

22. I hereby certify that I attended the deceased from **Feb. 17, 1949**, to **Jan. 30, 1951**, that I last saw the deceased alive on **Jan. 30, 1951**, and that death occurred at **10:00 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Arthur Rosser M.D.

2436 Washington Blvd. - 30

2/2/51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 2/3/51	NAME OF CEMETERY OR CREMATORY Balto. Cem.	LOCATION (City, town, or county) Balto., Md.	(State)
DATE REC'D BY LOCAL REG. February 3-1951		REGISTRAR'S SIGNATURE R.W.		24. FUNERAL DIRECTOR Wm. J. Lickner & Sons - Balto., Md.	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0248

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u>		LENGTH OF STAY (In this place) <u>19 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bosley Avenue</u>				STREET ADDRESS (If rural, give location) <u>Bosley Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth</u>		(First) <u>Stella</u>		(Last) <u>Mattingley</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>25 October, 1875</u>	
13. FATHER'S NAME <u>Jacob Thomas Adams</u>		14. MOTHER'S MAIDEN NAME <u>Susan McQuade</u>		9. AGE last birthday <u>75</u> yrs.	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Susan Mattingley, (daughter) Cockeysville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>450.0 Gastro - in fested hemorrhage</u>						<u>1 day</u>	
Antecedent cause(s) (b) <u>97 Heart failure - arterio sclerosis</u>						<u>8 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Anemia</u>						<u>6 months</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	
SUICIDE				INJURY		(COUNTY)	
HOMICIDE						(STATE)	
TIME (Month) (Day) (Year) (Hour)				INJURY OCCURRED		HOW DID INJURY OCCUR?	
OF				While at			
INJURY				Work <input type="checkbox"/> Not While <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>49</u> , to <u>13 Jan</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>11 Jan</u> , 19 <u>51</u> , and that death occurred at <u>12:45 P</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Kees</u>				(Degree or title) <u>M.D.</u>		DATE SIGNED <u>13 January 1951</u>	
ADDRESS <u>Cockeysville, Ind.</u>							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 16, 1951</u>		<u>New Cathedral</u>		<u>Cockeysville, Md.</u>	
DATE REC'D BY LOCAL REG <u>1/15/51</u>		REGISTRAR'S SIGNATURE <u>W. H. Hodrick</u>		24. FUNERAL DIRECTOR <u>Henry W. Jackson & Sons Co</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0249 37

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Garrison</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Garrison</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peinstown Rd.</u>		STREET ADDRESS (If rural give location) <u>70 Garrison Forest School</u>	
3. NAME OF DECEASED (Type or Print) <u>David</u> (First) <u>Everett</u> (Middle) <u>Mayne</u> (Last)		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>16</u> (Year) <u>1957</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>12/14/1888</u>
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. of Pledge & Grounds</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>213-01-1344</u>	
17. INFORMANT <u>Mary V. Mayne - Garrison Forest School</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary thrombosis</u>		<u>5 minutes</u>
940 Antecedent cause(s) (b) <u>arteriosclerosis of coronary arteries</u>		<u>2 yrs</u>
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>1946</u>	19b. MAJOR FINDINGS OF OPERATION <u>maligancy of rectum (apparently cured)</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1957, to Jan 16, 1957, that I last saw the deceased alive on 15 Jan 57, and that death occurred at 9:40 p.m., from the causes and on the date stated above.

SIGNATURE Paul X. Rayne M.D. ADDRESS Pikesville 8, Md. DATE SIGNED 16 Jan 51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>1/19/51</u>	NAME OF CEMETERY OR CREMATORY <u>London Park</u>	LOCATION (City, town or county) (State) <u>Pikesville 8, Md.</u>
DATE REC'D BY LOCAL REG. <u>1-18-51</u>	REGISTRAR'S SIGNATURE <u>J. E. McNeal</u>	24. FUNERAL DIRECTOR <u>Frank V. Powell</u>	ADDRESS <u>Pikesville 8, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0250

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>519 ANNESLIE RD.</u>		STREET ADDRESS (If rural, give location) <u>519 Anneslie Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edith</u> (Middle) <u>Keys</u> (Last) <u>McAnally</u>	4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 30, 1870</u>
9. AGE last birthday <u>80</u> yrs.		If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>1</u>	
13. FATHER'S NAME <u>Thomas W. Keys</u>		14. MOTHER'S MAIDEN NAME <u>Temperance Morris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>Mr. Robert C. McKee - 402 American Bldg.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Occlusion</u>		
Antecedent cause(s) (b) <u>Cerebral Vas. Accident, old c Hemiplegia</u>		<u>May 23, 1950</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive Arteriosclerotic C.V. Disease</u>		<u>10-15 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Had coronary attack Dec. 30, 1950. This caused her to faint & fall from the stairs (confusion of forehead)</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>+ abrasion</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec 30 50 600 p.m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>See report</u>

22. I hereby certify that I attended the deceased from Jan. 1950, to Jan. 4, 1951, that I last saw the deceased alive on Jan 4, 1951, and that death occurred at 4:45 p.m., from the causes and on the date stated above.

SIGNATURE See Mrs G. Hall (Degree or title) ADDRESS 2950 Edmondson Ave. Baltimore Md. DATE SIGNED Jan 4/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1/8/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u>	LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>
DATE REC'D BY LOCAL REG. <u>1/5/51</u>	REGISTRAR'S SIGNATURE <u>W. Sedwick</u>	24. FUNERAL DIRECTOR <u>Wm. J. Lickner & Sons - Balt.</u>	ADDRESS <u>Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard,</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>303 Pine St. Turners Station</u>	
3. NAME OF DECEASED (First) <u>LESLIE</u> (Middle) <u>(NMI)</u> (Last) <u>MCCORMICK JR.</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>10-24-18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Worker, Steel Co.</u>	9. AGE last birthday <u>32</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Winnsboro, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leslie McCormick Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Nancy MacLillie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW-2</u>		16. SOCIAL SECURITY NO. <u>251-18-5461</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Primary Carcinoma of Liver

unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec. 9, 1950, to Jan. 29, 1951, that I last saw the deceasedand that death occurred at 7:00 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M.D. ACTING CHIEF MEDICAL SER. VAH FT. HOWARD, MD.

1-29-51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb. 2-1951</u>	<u>Mt. Olive Cemetery</u>	<u>Chester, S.C.</u>	

DATE REC'D BY LOCAL REG. January 30, 1951 REGISTRAR'S SIGNATURE Chas. R. Law24. FUNERAL DIRECTOR
Chas. R. Law, 802 Madison Ave. Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

690336

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *0252* *45*

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Chase COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Oliver Baech		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chase	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) Redbird Rd & Sylvan Rd. Box 405 B	
3. NAME OF DECEASED (Type or Print) Elizabeth M. McConnell		4. DATE OF DEATH (Month) (Day) (Year) January 4, 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 30, 1885
9. AGE last birthday 65 yrs.		10. AGE last birthday If under 1 year: Months Days Hours Mins. 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME -- Nichol		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY No. none	
17. INFORMANT Mr. Stillman McConnell			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Carcinoma Stomach		approx 1 yr
Antecedent cause(s) (b) 151X 46b		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 151X 46b		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION Oct 1950	19b. MAJOR FINDINGS OF OPERATION carcinoma stomach & metastases	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Sept 1950 , to Jan 4, 1951 , that I last saw the deceased alive on Jan 2, 1951 , and that death occurred at 7:15 A m., from the causes and on the date stated above.		
SIGNATURE Joseph Shear M.D.		DATE SIGNED 1/5/51
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		NAME OF CEMETERY OR CREMATORY Ebenezer Cem.
DATE REC'D BY LOCAL REG. Jan 5, 1951		24. FUNERAL DIRECTOR Philip Hurley Sons
REGISTRAR'S SIGNATURE Earl Hurley		ADDRESS 2024 Orleans St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



40

Reg. Dist. No. 180

Reg. Dist. No. 180

1. PLACE OF DEATH: COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bradtsham</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bradtsham</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Brenda Karen McCracken</u>		4. DATE OF DEATH <u>January 28 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>3</u>	8. DATE OF BIRTH <u>Aug 17/30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>57 yr 11 mo</u>
13. FATHER'S NAME <u>Roy McCracken</u>		14. MOTHER'S MAIDEN NAME <u>Gay McCracken</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mr Gay M McCracken Bradtsham Md</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Septicemia</u>			<u>12 hr</u>
Antecedent cause(s) (b) <u>Otitis media, purulent</u>			<u>1 day</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>1/27</u> , 19 <u>51</u> , to <u>1/28</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1/27</u> , 19 <u>51</u> , and that death occurred at <u>10 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Lucas E Palmer MD</u>		ADDRESS <u>Bel Air, Md</u>	
DATE SIGNED <u>1/28/57</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>JAN. 31, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Wideners Valley</u>	LOCATION (City, town, or county) (State) <u>Glade Spring VA.</u>
DATE REC'D BY LOCAL REG. <u>1/29/51</u>	REGISTRAR'S SIGNATURE <u>Russell Woodward</u>	24. FUNERAL DIRECTOR <u>Joseph T. Foster</u>	ADDRESS <u>Bel Air Md</u>

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Town

2700

3000 Slip



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0254

Reg. Dist. No. 45

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middleboro</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middleboro</u> TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) First: <u>ROBERT</u> Middle: <u>S.</u> Last: <u>McLeod</u>	4. DATE OF DEATH (Month) <u>1</u> (Day) <u>24</u> (Year) <u>1951</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Dec 27, 1867</u>	9. AGE last birthday <u>83</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (State of foreign country) <u>Scotland</u>	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David McLeod</u>	14. MOTHER'S MAIDEN NAME <u>Mary Simpson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No. <u>NONE</u>	17. INFORMANT <u>Mrs. Bertha Belt, 1133 Grunmount</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Myocarditis, Chronic</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Senility</u>		
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of Prostate (Operated 1943)</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE (Degree or title) <u>David M. S. Ruppel, M.D.</u>		DATE SIGNED <u>1/25/51</u>
23. BURIAL INFORMATION REMOVAL (Specify)	DATE THEREOF <u>1/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Paul's</u>
LOCATION (City, town, or county) <u>Baltimore</u>	DATE REC'D BY LOCAL REG. <u>1/26/51</u>	REGISTRAR'S SIGNATURE <u>d. w. Redner</u>
24. FUNERAL DIRECTOR <u>W. H. S. S. S.</u>	ADDRESS <u>1219 St Paul St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

515246

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0255

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5219 Garmouth Rd.</u>		STREET ADDRESS (If rural, give location) <u>5219 Garmouth Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>NUGENT</u>	(Last) <u>McNALLY</u>
4. DATE OF DEATH	(Month) <u>Jan.</u>	(Day) <u>29,</u>	(Year) <u>1951</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>1/31/1870</u>
9. AGE last birthday <u>80</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Patrick Nugent</u>		14. MOTHER'S MAIDEN NAME <u>Jane McNally</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>(If year, give war or dates of service)</u>	
17. INFORMANT AND ADDRESS <u>Mrs. H. Royal Williams - 5219 Garmouth Rd.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Ante-natal C.V. disease</u>			
Antecedent cause(s) (b) <u>Cirrhosis Liver</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July, 1947, to Jan., 1951, that I last saw the deceased alive on Jan 29, 1951, and that death occurred at 9:30 A.m., from the causes and on the date stated above.

SIGNATURE C. J. Lubinski ADDRESS 1945 W. B. 1st St. 1/31/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2/1/51</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/21/51</u>	REGISTRAR'S SIGNATURE <u>Geo. Hedrick</u>	24. FUNERAL DIRECTOR <u>Wm. J. Dickner & Sons</u>	ADDRESS <u>Balto., Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0256

CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN 2923 W. North Avenue	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) Baltimore, Maryland ✓	
3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) A.	(Last) METZEL
4. DATE OF DEATH	(Month) January	(Day) 20	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 7-23-73
9. AGE last birthday 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	11. BIRTHPLACE (State or foreign country) Harford Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jacob Metzel	
14. MOTHER'S MAIDEN NAME Alice Ann Brooks		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes SAW	
16. SOCIAL SECURITY No. Unknown		17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **CARCINOMA OF PROSTATE**

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 7**, 19**51**, to **Jan. 20**, 19**51**, and that death occurred at **3:45 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

VINCENT O. EARECKSON, M.D.**VAH, FORT HOWARD, MARYLAND****1-20-51**23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF **1/23/51** NAME OF CEMETERY OR CREMATORY **Mount Olive Cemetery** LOCATION (City, town, or county) **Baltimore, Maryland** (State)DATE REC'D BY LOCAL REG. **1/22/51** REGISTRAR'S SIGNATURE **A. C. Belcher** 24. FUNERAL DIRECTOR **Howard Blight Funeral Home** ADDRESS **6009 Harford Rd., Baltimore, Maryland**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0257

CERTIFICATE OF DEATH

Reg. Dist. No. 41

FILM No. G 130 FEB 2 1951

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
TOWN <u>Dundalk</u> LENGTH OF STAY (in this place) <u>35 years</u>		TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1916 Augusta Ave.</u>		STREET ADDRESS (If rural, give location) <u>1916 Augusta Ave</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Wladyslaw</u> <u>Helen</u> <u>Milewski</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan.</u> <u>9</u> <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>April 22 1885</u>
9. AGE last birthday <u>65</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Pieczkowski</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cancer of Uterus

INTERVAL BETWEEN ONSET AND DEATH

14 Mos.

Antecedent cause(s)

(b)

with metastases (Germans)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

Nov. 1949

CA. of Uterus

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 50, 1950, to JAN. 9, 1951, that I last saw the deceased

alive on JAN. 8, 1951, and that death occurred at 3:45 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial

Jan 12/51

Washed Heart of Mary

Balto. County

1/10/51

1/11/51

G. W. Hedding

John M. Weber

4015 Chester Street

Balto. Md.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0258

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Essex		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore 21 Essex	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 418 Beck Avenue		STREET ADDRESS (If rural, give location) 418 Beck Avenue	
3. NAME OF DECEASED (Type or Print)	(First) THOMAS	(Middle) V.	(Last) MOHR
4. DATE OF DEATH	(Month) January	(Day) 26,	(Year) 1951
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Dec 18 - 1950
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 1 yrs. 1 Months 1 Days 1 Hours 1 Min.
11. BIRTHPLACE (State or foreign country) BALTO CITY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME KERNON MOHR		14. MOTHER'S MAIDEN NAME Pauline R Doda	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. Mr KERNON MOHR 418 Beck Ave. Essex Md	
17. INFORMANT		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Congenital heart disease (Cor uniloculare)		
Antecedent cause(s) (b) 754.4 159e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE (Degree or title) R. S. Fisher		DATE SIGNED
M.D. 700 Fleet St., Baltimore 2, Md.		
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1/27-1951	NAME OF CEMETERY OR CREMATORY Lion Luth - Cem
DATE REC'D BY LOCAL REG. January 27 - 1951	REGISTRAR'S SIGNATURE R. W.	LOCATION (City, town, or county) (State) BALTO Md
24. FUNERAL DIRECTOR		ADDRESS Lansdale Funeral Home 1401 Belair Rd Md

2-1-18-0-30-2-40-5 ✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0259 38

1. PLACE OF DEATH- COUNTY <u>Parkville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7802 OAK Avenue</u>		STREET ADDRESS (If rural, give location) <u>7802 OAK Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mary Emma Jane Montgomery</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 16 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>widowed</u>	8. DATE OF BIRTH <u>May 29-1867</u> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Phillip De Baugh</u>		14. MOTHER'S MAIDEN NAME <u>Mary P. Flaherty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mr. WM Montgomery-7802 Oak Ave</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute cardiac failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic myocarditis with general- ized hypertensive arteriosclerosis

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

none

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT

(Specify)

SUICIDE none

HOMICIDE

PLACE (Home, farm, factory, street, OF office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour)

OF INJURY none

m.

INJURY OCCURRED

While at Work ☐

Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/20, 1938, to Jan. 16, 1951, that I last saw the deceased

alive on Jan. 16, 1951, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

A. M. Bacon, M.D. 2810 Taylor Ave. Jan. 16/51

23. BURIAL, CREMATION

REMOVAL* (Specify)

Burial

DATE THEREOF

1/19/51

NAME OF CEMETERY OR CREMATORY

Morland Park

LOCATION (City, town, or county)

Balto Md.

(State)

DATE REC'D BY LOCAL REG.

1/16/51

REGISTRAR'S SIGNATURE

A. M. Bacon

24. FUNERAL DIRECTOR

L. J. Kuek

ADDRESS

5305 Harford Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0260 41

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1905 Willow Springs Rd</u>		STREET ADDRESS (If rural, give location) <u>1905 Willow Springs Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MAY</u>	(Middle) <u>MORGAN</u>	(Last) <u>MORGAN</u>
4. DATE OF DEATH	(Month) <u>JAN</u>	(Day) <u>20</u>	(Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Aug 26 1881</u>
9. AGE last birthday <u>69</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>COLUMBIA, S.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>HERON</u>	14. MOTHER'S MAIDEN NAME <u>W. Boyd Cook</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1905 Willow Springs Rd</u>	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

420.1

Antecedent cause(s)

93 d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

48 hrs.

10 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 18, 1951 to Jan 20, 1951, that I last saw the deceased alive on Jan 18, 1951, and that death occurred at 7:29 p.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>1/23/1951</u>	<u>PARKWOOD CEM.</u>	<u>BALTO. Co., MD.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan 23-1951</u>	<u>William J. Kelly</u>	<u>WILLIAM FUNERALS HOME</u>	<u>2113 DUNDALK AVE.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Balto Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Fullerton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fullerton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 467 Phila. Rd</u>		STREET ADDRESS (If rural, give location) <u>Box 467 Phila. Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lawrence</u>	(Middle)	(Last) <u>Navitskis</u>
4. DATE OF DEATH	(Month) <u>Jan</u>	(Day) <u>2</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1/26/1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>1</u> yrs. <u>11</u> Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Balto Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Anthony Navitskis</u>		14. MOTHER'S MAIDEN NAME <u>Leona C. Kulacki</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>6</u>	
17. INFORMANT AND ADDRESS <u>Anthony Navitskis 467 Phila. Rd.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Suffocation</u>			<u>15 min</u>
Antecedent cause(s) (b) <u>Catarrhal Croup, acute</u>			<u>24 hrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>105</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-1, 1951, to 1-2, 1951, that I last saw the deceased alive on 1-1, 1951, and that death occurred at 8:45 A m., from the causes and on the date stated above.

SIGNATURE <u>Clifford F. Hudson, M.D.</u>	DATE <u>1/2/51</u>	ADDRESS <u>Lark Md.</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>1/4/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Stephens</u>
LOCATION (City, town, or county) (State) <u>Brackton MD</u>	24. FUNERAL DIRECTOR <u>John S. ...</u>	ADDRESS <u>1214 St Paul St</u>
DATE REC'D BY LOCAL REG. <u>1-3-50</u>		
REGISTRAR'S SIGNATURE <u>John S. ...</u>		

2-1-260-24-3-36-4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

50-#1891

52.1007

0261

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0262

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1616 Lynch Rd.</u>		STREET ADDRESS (If rural give location) <u>1616 Lynch Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE WILLET NELSON</u>	(First) (Middle) (Last)	4. DATE OF DEATH <u>1-5-51</u>	(Month) (Day) (Year)
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB. 5 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>BETH STEEL Co.</u>	11. BIRTHPLACE (State or foreign country) <u>DANVILLE ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>ANDREW NELSON</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE HIRLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO.</u>	
17. INFORMANT <u>MRS. ALMA NELSON 1616 LYNCH RD.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>			
Antecedent cause(s) (b) <u>Hypertensive Cardio-Vascular Disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Disease</u>			<u>1-34</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE Dr. J. W. Davis (Degree or title) ADDRESS 1191 E. Egan - Dundalk - Md. DATE SIGNED 1/8/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>1/9/51</u>	<u>OAK Lawn</u>	<u>BALTO. Co.</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/8/51</u>	<u>G. W. Haffner</u>	<u>ULLRICH FUNERAL HOME</u>	<u>685336 DUNDALK MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0263

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>2811 Del Mar ave Edgemere</u> TOWN <u>Edgemere</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2811 Del Mar ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u> TOWN <u>Edgemere</u> STREET ADDRESS (If rural, give location) <u>2811 Del Mar ave</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>John</u>	<u>Raymond</u>	<u>Nevedale</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>SEPT 15 1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>4</u> yrs. If under 1 year Months <u>4</u> Days <u>8</u> Hours <u>19</u> Min. <u>57</u>
11. BIRTHPLACE (State or foreign country) <u>Edgemere Balto. city Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Nevedale</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>Joseph Nevedale</u>		<u>2811 Del Mar ave</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
481x Immediate cause (a) <u>Influenza</u>		
23b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>-</u>		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 16, 1951, to Jan. 18, 1951, that I last saw the deceased alive on Jan. 16, 1951, and that death occurred at 9 A.m., from the causes and on the date stated above.

SIGNATURE <u>R. W. Hedrick</u>	(Degree or title) <u>m. d.</u>	ADDRESS <u>520 08th St. Balto. Md.</u>	DATE SIGNED <u>1-18-51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 20 1951</u>	<u>Sacred Heart of Mary</u>	<u>Balto. County</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1/19/51</u>	<u>R. W. Hedrick</u>	<u>John W. Weber</u>	<u>401 S. Chester St. Balto. Md.</u>

2-0-118-124-2-40-5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

55-19-692

11-16-14

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 yrs

Hospital, institution, or street address where death occurred:

3017 Pennsylvania Ave

How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Rosemont
(If outside city or town limits, write RURAL and give nearest town)Street No. 3017 Genoa Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Margaret J. Morris

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife George F.7. Birth date of deceased (mo., day, yr.) May 17, 18838. (c) If alive, give age 79 years

8. AGE:

Years

Months

Days

If less than one day

67725

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

FATHER

12. Name

Thomas Carey

13. Birthplace

Ireland

MOTHER

14. Maiden name

Mary Ester

15. Birthplace

Ireland

16. Informant

Mr. Geo F. Morris

Address

3017 Pennsylvania Ave Rosemont Md

17. (Burial, cremation, or removal) Which?

Burial

Date thereof

1/15/57
(month) (day) (year)

Cemetery or crematorium

Louisa East Ave

Location

3801 Frederick St. Ave

18. Funeral director

Tom Howard & Son

Address

901 Phillips Street

19. (To be filled by registrar)

1-12-57A.W. Hedrich

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1957 at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/10 1946 to 1/11/57 1957and that I last saw him alive on 1/11/57 1957

Immediate cause of death

Acute Cardiac Failure

DURATION

1 da

Due to

Cardiovascular Renal Disease

Due to

Other conditions

442x131a

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph G. Launkaitis MD

M. D. or other

Address

675 Washington StDate signed 1/14/57

MARGIN RESERVED FOR BINDING

VS A15

9-15-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0264

0265

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. N. *EX*

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 15	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 2650 Oswego Avenue	
3. NAME OF DECEASED (Type or Print) JOHN (First) C. (Middle) O'NEILL, JR. (Last)		4. DATE OF DEATH January 22 (Month) 1951 (Day) (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 12-11-90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Standard Oil		10b. KIND OF BUSINESS OR INDUSTRY retired	9. AGE last birthday 60 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John C. O'Neill, Sr.		14. MOTHER'S MAIDEN NAME Katherine Trink	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown 220-97-1751	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH
Unknown

Immediate cause

(a) **CORONARY ARTERIOSCLEROSIS, SEVERE**
OLD & RECENT MYOCARDIAL INFARCTION, DUE TO ABOVE.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Jan 23/51	NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	LOCATION (City, town, or county) Baltimore, Maryland	(State)
DATE REC'D BY LOCAL REG. 2/23/51	REGISTRAR'S SIGNATURE L	24. FUNERAL DIRECTOR Stewart & Mowen Co.	ADDRESS 108 W. North Avenue Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>117 W. 22nd Street</u>	
3. NAME OF DECEASED (First) <u>ANDREW</u> (Middle) <u>L.</u> (Last) <u>PAGE</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>21</u> (Year) <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8-23-90</u>
9. AGE last birthday <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Page</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Butler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) UREMIA

INTERVAL BETWEEN ONSET AND DEATH

UNKNOWN

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) ARTERIOSCLEROTIC CARDIOVASCULAR-RENAL DISEASEUNKNOWN

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 15, 1951 to Jan. 21, 1951, that I last saw the deceasedand that death occurred at 9:00 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICES, VAH, FORT HOWARD, MD. 1-22-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mrs. Katie R. Williams 322 N. SchroederSt., Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

MARYLAND STATE DEPARTMENT OF HEALTH

0267

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Turners Station</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Turners Station</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Turners Station, Balto. Co., Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Linwood</u>	(Middle)	(Last) <u>Palmer</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 25, 1898</u>
9. AGE last birthday <u>51</u> yrs.		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>24</u> (Year) <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Halifax, Halifax Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Hack Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Lilfaimie Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>216-10-3179</u>	
17. INFORMANT <u>Nellie A. Palmer (wife)</u>		<u>620 Peach Orchard Lane</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Immediate cause</u> <u>163x Carcinoma of Right Lung</u>		<u>3 yrs.</u>
(b) <u>Antecedent cause(s)</u> <u>47d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/>		
SIGNATURE <u>Dr. J. S. Davis</u>		DATE SIGNED <u>1/25/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>1/29/51</u>	NAME OF CEMETERY OR CREMATORY <u>Abraham Memorial Park</u>
LOCATION (City, town, or county) <u>Balto., Co.</u>	(State)	
DATE REC'D BY LOCAL REG. <u>1/26/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Charles R. Law - 802 Madison Ave.</u>
ADDRESS		

690336

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0268 31 4771

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - RANDALLSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - RANDALLSTOWN</u>	
HOSPITAL OR INSTITUTION-OR STREET ADDRESS <u>OFFUTT Rd.</u>		STREET ADDRESS (If rural, give location) <u>OFFUTT Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>WARREN</u> (Middle) <u>WILLIAM</u> (Last) <u>PARRISH</u>	4. DATE OF DEATH (Month) <u>1</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 10, 1891</u>
9. AGE last birthday <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINE MAN - GAS & ELECTRIC</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WARREN WILLIAM PARRISH</u>		14. MOTHER'S MAIDEN NAME <u>AGNES BRYAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-5979</u>	
17. INFORMANT AND ADDRESS <u>WIFE - MRS. ELIZABETH PARRISH - OFFUTT Rd. RANDALLSTOWN</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CARCENOMA OF LUNG

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH
13 MONTHS

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>16 FEB. 1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>CARCENOMA OF LUNG.</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from DEC. 1, 1949, to 1/6, 1951, that I last saw the deceased alive on 1/6, 1951, and that death occurred at 3:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Edwin G. Pierpont, M.D.

8027 LIBERTY Rd. BALTA 7, Md. 1/6/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/9/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cem.</u>	LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>1/8/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hadush</u>	24. FUNERAL DIRECTOR <u>Wm. J. Fickner & Sons - Balto.</u>	ADDRESS <u>690 588 Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>BALTIMORE CO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SHADY NOOK NURSING HOME</u>		STREET ADDRESS (If rural give location) <u>421 OVERBROOK ROAD</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>EMMA LUCINDA PATTEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 31 1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT. 28 1876</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM HENRY KEILHOLTZ</u>		14. MOTHER'S MAIDEN NAME <u>EMMA HEROLDT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WALTER E. PATTEN, JR.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
193x Immediate cause 54b Antecedent cause(s)		(a) <u>Anaplastic carcinoma of the cauda equina</u>		Approx 3 mos.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death		(c) <u>Atherosclerotic Hypertensive CVD</u>			
19a. DATE OF OPERATION <u>Dec. 8, 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Invasive tumor of cauda equina</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11/28, 1950, to 1/31, 1951, that I last saw the deceased alive on 1/31, 1951, and that death occurred at 9:40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Herbert J. Leitch, M.D. 5305 East Drive Balto -27, Md. 2/1/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb 3/51</u>	NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>	LOCATION (City, town, or county) (State) <u>Colona Md</u>
DATE REC'D BY LOCAL REG. <u>2-1-51</u>	REGISTRAR'S SIGNATURE <u>V.E. Harvey</u>	24. FUNERAL DIRECTOR <u>J.E. Tyson</u>	ADDRESS <u>Rising Sun Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0270 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hanover Road</u>		STREET ADDRESS (If rural give location) <u>Hanover Road</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Emory</u> (Middle) <u>Perego</u> (Last)		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 8 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Retired Carpenter Construction work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Benjamin Perego</u>		14. MOTHER'S MAIDEN NAME <u>Hester Bull</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>212-18-5738</u>	
		17. INFORMANT <u>Raymond Perego Reisterstown Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
1. Immediate cause (a) <u>Coronary Occlusion</u>		
2. Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>		<u>5 year</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchopneumonia</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>-</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>44</u> , to <u>Jan.</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan. 24</u> , 19 <u>51</u> , and that death occurred at <u>10 p.</u> m., from the causes and on the date stated above.		
SIGNATURE <u>J. Walter Landon, M.D.</u>		DATE SIGNED <u>Jan. 26, 1951</u>
ADDRESS <u>Reisterstown Md.</u>		
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan 27 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Reisterstown Meth Cem.</u> LOCATION (City, town, or county) <u>Reisterstown Md</u>
DATE REC'D BY LOCAL REG. <u>1-26-51</u>	REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>	24. FUNERAL DIRECTOR <u>Wm Berryman & Sons Reisterstown Md</u>

510246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0271

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockdale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockdale - rural Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3628 Milford Mill Rd.</u>		STREET ADDRESS (If rural, give location) <u>3628 Milford Mill Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>CHRISTINA PFEIFFER</u>		4. DATE OF DEATH <u>1/25/51</u>	
(First) (Middle) (Last)		(Month) (Day) (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 14, 1868</u>
9. AGE last birthday <u>82</u> yrs.		If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Kroll</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. C.W. Sharp- 3628 Milford Mill Rd.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerotic C.V. disease

INTERVAL BETWEEN ONSET AND DEATH

10 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 1, 1940 to Jan 25, 1951, that I last saw the deceased

alive on Jan 25, 1951, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE John R. Korthman, M.D. (Degree or title) ADDRESS

DATE SIGNED

1/26/51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
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DATE REC'D BY LOCAL REG. <u>January 21, 1951</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u>	ADDRESS <u>BALTO., MD.</u>
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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 027233

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Wings Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pleasant Hill, Wings Mills.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Reisterstown, Road</u>		STREET ADDRESS <u>Reisterstown, Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Amelia</u>	(Middle) <u>Burns</u>	(Last) <u>Pierce</u>
4. DATE OF DEATH	(Month) <u>Jan.</u>	(Day) <u>8</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 27 1891</u>
9. AGE last birthday <u>59</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William F. Burns</u>		14. MOTHER'S MAIDEN NAME <u>Clara Grempler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>218-18-9501</u>	
17. INFORMANT AND ADDRESS <u>John T. Pierce, Lutherville, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma of uterus

Antecedent cause(s)

174 X
486Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

(c)

Cachexia

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN
ONSET AND DEATH4 yrs

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Nat While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1-1-51 to 1-7-51, that I last saw the deceased
alive on 1-7-51, 1951, and that death occurred at 9:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Jan. 11, 1951</u>	<u>Gruid Ridge</u>	<u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1-9-51</u>	<u>Mary B. Eline.</u>	<u>J.F. Eline & Sons</u>	<u>Reisterstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



0273

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u> TOWN <u>Dundalk 22</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>213 Calgate ave</u>		MARYLAND LENGTH OF STAY (In this place) <u>28</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> TOWN <u>Same</u> STREET ADDRESS (If rural, give location) <u>Same</u>	
3. NAME OF DECEASED (Type or Print) <u>Emidio</u> (First) <u>Pignotti</u> (Last)		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>20</u> (Year) <u>51</u>		5. SEX <u>male</u>	
6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Dec 23 1896</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shearer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wk Met Co</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>213-09-0781</u>		17. INFORMANT <u>BETHELEHM STEEL CO. SPS. POINT.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary occlusion
 Antecedent cause(s) (b) 94a
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH
10 min.

11. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY?
 Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) Dr. M. J. Pignotti M.D. **ADDRESS** Dundalk 22 Md. **DATE SIGNED** 1/20/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>1/22/51</u>	NAME OF CEMETERY OR CREMATORY <u>CAK LAWN</u>	LOCATION (City, town, or county) <u>BALTIMORE, MD.</u>
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DATE REC'D BY LOCAL REG. <u>Jan. 21-1951</u>	REGISTRAR'S SIGNATURE <u>William M. Kelly</u>	24. FUNERAL DIRECTOR <u>Walter Brooks Bradley, Dundalk, Md.</u>	ADDRESS
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

396

JUN 23 1951
U.S. AIR FORCE
D

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0275

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
TOWN <u>Catonsville</u>		TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>127 Oakdale Rd</u>		STREET ADDRESS (If rural give location) <u>127 Oakdale Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Charles Leonard Pochlmann</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 23 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-26-77</u>
9. AGE last birthday <u>79 yrs.</u>		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Partner and Share Seafood Wholly</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Christian Pochlmann</u>		14. MOTHER'S MAIDEN NAME <u>Louise Gessel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>212-07-7903</u>	
17. INFORMANT <u>Mrs Agnes Jamison 127 Oakdale Rd</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute cardiac failure

Antecedent cause(s)

(b) Cardiovascular disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>11/26/51</u>	<u>Salem Lutheran</u>	<u>Catonsville</u>	<u>md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>1-24-51</u>	<u>J. E. Harry</u>	<u>Edison Sons Catonsville</u>		

290636

md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

Le Magna
N. S. P.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0276 30

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>757 West Fayette Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ANDREW</u> <u>POLLITT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 22 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 22, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal business</u>	9. AGE last birthday <u>77</u> yrs. <u>77</u> Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Wicomico County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Anthony Pollitt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Virginia Anderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No. <u>Hospital Records</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized arteriosclerosis

(c) Diabetes mellitus

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 1, 1950, to Jan. 22, 1951, that I last saw the deceased alive on Jan. 22, 1951, and that death occurred at 6:15 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/23/51</u>	<u>Holy Cross</u>	<u>A. G. Co. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/23/51</u>	<u>A. W. Redman</u>	<u>Wm Cook Inc</u>	<u>1217 St. Paul St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

490626

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0277 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8430 Greenway Lock Raven Village Apts.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> TOWN STREET ADDRESS (If rural give location) <u>8430 Greenway, Lock Raven Village Apt</u>	
3. NAME OF DECEASED (Type or Print) <u>Florence Virginia Mace Putnam</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>25,</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 23, 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>84</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mln.
11. BIRTHPLACE (State or foreign country) <u>Rossville, Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dr. Wm. H. Mace</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Maria Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Rebecca M. Walker-8430 Greenway</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral arterial thrombosis

INTERVAL BETWEEN ONSET AND DEATH

3 weeks

Antecedent cause(s)

(b)

Arteriosclerosis

14 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Senility

14 yrs.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug 4th, 1950, to Jan 25th, 1951, that I last saw the deceased

alive on Jan 24th, 1951, and that death occurred at 5:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>1-27-51</u>	NAME OF CEMETERY OR CREMATORY <u>Mace burial plot</u>	LOCATION (City, town, or county) <u>Near Stemmers' Run, Md.</u>	(State)
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DATE REC'D BY LOCAL REG. <u>1/26/51</u>	REGISTRAR'S SIGNATURE <u>A. S. Clayton</u>	24. FUNERAL DIRECTOR ADDRESS <u>John O. Mitchell & Sons, Inc.-1900 Eutaw Place Baltimore, Maryland</u>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3/

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6 Hawthorne Ave.</u>		STREET ADDRESS (If rural give location) <u>6 Hawthorne Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Laura</u>	(Middle) <u>B.</u>	(Last) <u>Quillin</u>	4. DATE OF DEATH (Month) <u>January</u> (Day) <u>14</u> (Year) <u>19 51</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 7, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>86</u> yrs. <u>86</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Carroll County, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Sabert Trott</u>		14. MOTHER'S MAIDEN NAME <u>Emily Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. Ida Louise Trott</u>		<u>6 Hawthorne Ave. Pikesville, Md.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Intestinal Obstruction</u>	<u>1 wch</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Metastatic Carcinoma</u>	
(c) <u>Carcinoma of Intestines</u>	<u>?</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/7/, 1951, to 1/14/, 1951, that I last saw the deceased alive on 1/13/, 1951, and that death occurred at 8 P. m. from the causes and on the date stated above.

SIGNATURE <u>Wm. E. Martin M.D.</u>	(Degree or title)	ADDRESS <u>Pandallstown Harrisenville, Md.</u>	DATE SIGNED <u>1/15/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 17, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>New Oakland Cemetery</u>	LOCATION (City, town, or county) (State) <u>Carroll County, Md.</u>

DATE REC'D BY LOCAL REG. <u>1/15/51</u>	REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>	24. FUNERAL DIRECTOR <u>Wm. E. Martin</u>	ADDRESS <u>4510 Liberty Heights Ave.</u>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition MARYLAND STATE DEPARTMENT OF HEALTH

in 18 shown on:

2411 N. Charles Street, Baltimore

0279

FAM No. G 130 FEB 14 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Balto.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Fusting Ave. House in the Pines		STREET ADDRESS (If rural, give location) 636 N. Bend Rd.	
3. NAME OF DECEASED (Type or Print) HENRY		4. DATE OF DEATH Jan. 31, 1951	
5. SEX male		6. COLOR OR RACE white	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed		8. DATE OF BIRTH Nov. 24, 1872	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY Machinists	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Haney C. Rau		14. MOTHER'S MAIDEN NAME Anna C. Henkel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-07-9217 A	
17. INFORMANT AND ADDRESS Mrs. Inez Strohmeier, 8212 Northview Rd.		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Acute Myocardial De-compensation		2 da.	
Antecedent cause(s) (b) Chr. Hypertensive Cardiac Vascular Disease		10 yrs.	
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Aneurysm Abdominal Aorta, nonsyphilitic		(2/13/51 ago)	
11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 4-20 , 1939, to 1-31 , 1951, that I last saw the deceased alive on 1-31 , 1951, and that death occurred at 7:15 a.m. , from the causes and on the date stated above.			
SIGNATURE William K. Gallagher M.D.		DATE SIGNED 2-7-51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		NAME OF CEMETERY OR CREMATORY Loudon Park	
DATE THEREOF 2/3/51		LOCATION (City, town, or county) Balto., Md.	
24. REGISTRAR'S SIGNATURE R.W. Hedrick		25. FUNERAL DIRECTOR Wm. J. Lickner Sons - Balto Md.	
DATE RECD BY LOCAL REG. 2/2/51		ADDRESS 490617	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1289 30

1. PLACE OF DEATH- COUNTY <u>BALTIMORE CO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>46 GLENWOOD AVE</u>		STREET ADDRESS (If rural, give location) <u>(None)</u>	
3. NAME OF DECEASED (Type or Print) <u>THOMAS R. RAY</u>		4. DATE OF DEATH <u>1/14/51</u> 19 <u>51</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>3/18/1889</u> 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WM. RAY</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN RYAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Helen H. Ray</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Acute congestive heart failure</u>		
Antecedent cause(s) (b) <u>Arteriosclerotic Cardiovascular Disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pulmonary fibrosis + emphysema</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/4, 1950, to 1/14, 1951, that I last saw the deceased alive on 1/12, 1951, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/17/51</u>	<u>Touhid Park</u>	<u>Baltimore MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1-17-51</u>	<u>T.E. Harry</u>	<u>MACNABB + SON</u>	<u>28</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0281

1. PLACE OF DEATH COUNTY <u>Balto 19</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>as</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparranville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>in</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2913 Klenius Lane</u>		STREET ADDRESS <u># 1</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Ella</u> (First) <u>Reed</u> (Last)		4. DATE OF DEATH <u>Jan. 4</u> (Month) <u>4</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>about 1893</u>
9. AGE last birthday <u>57</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Chaustamae Cockerell</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <u>arteriosclerosis</u>	(a)	INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Interstital chronic nephritis (with uremia)</u>	(b)	<u>1 week</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1949 to Jan 3, 1951, that I last saw the deceased alive on Jan 3, 1951, and that death occurred at 12 30 A m., from the causes and on the date stated above.

SIGNATURE <u>Laura H. Tollin</u>	(Degree or title)	ADDRESS <u>M. R. 6908 North Point Rd Balto 19</u>	DATE SIGNED <u>Jan 4 1951</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/6/50</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>	LOCATION (City, town, or county) <u>A. A. County</u>
DATE REC'D BY LOCAL REG. <u>1-5-51</u>	REGISTRAR'S SIGNATURE <u>Edw. Hedrick</u>	24. FUNERAL DIRECTOR <u>Mrs. R. A. Elliott & Dgts.</u>	ADDRESS <u>1129 N. Caroline St.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0282

1. PLACE OF DEATH County <u>Baltimore</u> City or town <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>5225 Garmouth Rd.</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md.</u> County <u>Baltimore</u> City or town <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>5225 Garmouth Rd.</u> (If rural, give LOCATION) 2. (a) If veteran, name war			
3. (a) FULL NAME <u>Helen Dorothy Rein</u>				3. (b) Social Security Number			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife <u>Charles Louis Rein</u>				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>Nov. 21, 1904</u>				8. AGE: Years <u>46</u> Months Days If less than one day hrs. min.			
9. Birthplace <u>Baltimore, Md.</u> (Town, county, and state)				10. Usual occupation <u>H. W.</u>			
11. Industry or business <u>Own Home</u>				12. Name <u>Geo. Wood</u>			
13. Birthplace <u>Anna Gemp</u>				14. Maiden name <u>131a</u>			
15. Birthplace <u>C. Louis Rein</u>				16. Informant <u>5225 Garmouth Rd.</u>			
17. Burial (Burial, cremation, or removal. Which?) <u>Jan. 15/51</u> (month) (day) (year) Cemetery or crematory <u>Baltimore National</u> Location <u>5501 Frederick Rd. Balto. 29. Md.</u>				18. Funeral director <u>Harry A. Witzke</u> Address <u>4101 Edmondson Ave.</u>			
19. Date received by registrar <u>January 13, 1951</u>				20. DATE OF DEATH <u>Jan. 12/51</u>			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>10 August 1948</u> to <u>12 Jan 1951</u> and that I last saw her alive on <u>11 Jan 1951</u> Immediate cause of death <u>Cerebral hemorrhage, massive,</u> <u>Hypertensive cardio-vascular</u> <u>renal disease</u> Other conditions <u>442X</u> <u>131a</u> (Include pregnancy within 3 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?							
23. SIGNATURE <u>Emil H. Henning, Jr. M.D.</u> Address <u>601 Winans Way</u> Date signed <u>13 Jan 51</u>							

 R.W.
 Registrar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Parkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rayville Road</u>		STREET ADDRESS (If rural, give location) <u>Rayville Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Eva</u> (First) <u>Agnes</u> (Middle) <u>Ridgley</u> (Last)		4. DATE OF DEATH <u>January 15</u> (Month) <u>1951</u> (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>23 August 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elias K. Frank</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Morrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Emily Ricketts, Parkton</u>	
17. INFORMANT AND ADDRESS <u>Emily Ricketts, Parkton</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4200 Immediate cause (a) <u>Heart Failure</u>		<u>1 1/2 years</u>
93d Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>		<u>? years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Heart Failure</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept., 1950, to Jan., 1951, that I last saw the deceased alive on 15 Jan., 1951, and that death occurred at 4:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Walter T. KeenM.D.Cockeysville, Md.15 Jan. 1951

23. BURIAL, CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>		<u>Jan 18, 1951</u>	<u>St. Mary's Hampden</u>	<u>Poland Ave</u>	<u>Md</u>
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>1/17/51</u>		<u>R.W. Hedrick</u>	<u>Justin E. Donovan - 3818 Poland Ave</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0284 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1104 Stevenson Lane</u>		STREET ADDRESS <u>1104 Stevenson Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>IRVIN EDWARD RITTERPUSCH</u>		4. DATE OF DEATH <u>Jan 1 1951</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 14 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Col. United States Army</u>		10b. KIND OF BUSINESS OR OCCUPATION <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Conrad Ritterpusch</u>		14. MOTHER'S MAIDEN NAME <u>Anna Loehr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Carrie Rappe Ritterpusch Same</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

Antecedent cause(s)

(b)

Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

31 hrs.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY m. ☐ While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 31 Dec., 1950, to 1 Jan., 1951, that I last saw the deceased

alive on 1 Jan., 1951, and that death occurred at 9:10 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

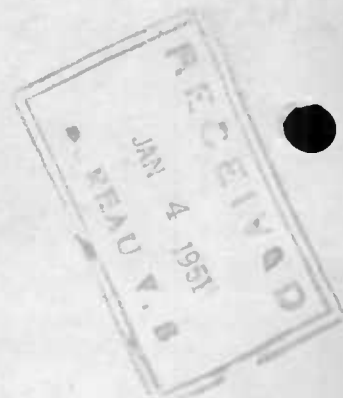
MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290636

Rt H Allison
4 Buckleugh Square
Towson



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0285

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>725 N. Carey Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHN</u>	(Middle) <u>E.</u>	(Last) <u>ROBINSON</u>
4. DATE OF DEATH	(Month) <u>January</u>	(Day) <u>11</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-2-87</u>
9. AGE last birthday <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John E. Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Annie L. Comager</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>CHRONIC GLOMERULONEPHRITIS</u>		UNKNOWN
Antecedent cause(s) (b) <u>592x Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1951 to Jan. 11, 1951, that I last saw the deceased

on Jan. 11, 1951 and that death occurred at 4:10 A.M., from the causes and on the date stated above.

SIGNATURE Paul Padgett ADDRESS Baltimore, Maryland DATE SIGNED 1-11-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>January 15, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State)
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DATE REC'D BY LOCAL REG. <u>January 15, 1951</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>James A. Hayes</u>	ADDRESS <u>638 N. Gilmore, Baltimore, Maryland</u>
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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

250679

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH: COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson, rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Balto. Co. Home,</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Arthur</u> (Middle) <u>E</u> (Last) <u>Roxby</u>	4. DATE OF DEATH (Month) <u>January</u> (Day) <u>16</u> (Year) <u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March 28, 1968</u>
9. AGE last birthday <u>82</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Arthur J. Roxby</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hubbard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>from records Baltimore Co Home.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.0 Immediate cause (a) <u>Pulmonary edema</u>		<u>1 wk.</u>
Antecedent cause(s) (b) <u>Chronic atherosclerotic heart disease</u>		<u>years</u>
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 8, 1950, to Jan. 15, 1951, that I last saw the deceased alive on Jan. 15, 1951, and that death occurred at 1:45 a.m., from the causes and on the date stated above.

SIGNATURE <u>Elizabeth B. Shrevel</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Cockeysville</u>	DATE SIGNED <u>1/16/51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>Jan. 19/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	LOCATION (City, town, or county) (State) <u>Gene Randall Md.</u>
DATE REC'D BY LOCAL REG. <u>1/16/51</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Chilcoat</u>	24. FUNERAL DIRECTOR <u>Wm. Cook & Sons</u>	ADDRESS <u>1217 St. Paul Street</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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JUN 10 1961
LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0287

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <i>Edgemore Ind. Balt. County</i>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Ind.</i> COUNTY <i>Balto.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Edgemore</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Edgemore</i>	
TOWN <i>Life</i>		TOWN <i>Edgemore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <i>North Point Rd. & Matthews</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>George</i>	(Middle) <i>G.</i>	(Last) <i>Rummel</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>6-22-1898</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	9. AGE last birthday <i>52</i> yrs. <i>1951</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Phillip A Rummel</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-09-9756</i>	
17. INFORMANT <i>Francis Rummel</i>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <i>Coronary Occlusion</i>			
Antecedent cause(s) (b) <i>44a</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>7</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Heart</i>		PLACE (Home, farm, factory, street, office bldg., etc.) <i>INJURY</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>m.</i>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>W. J. Supple</i>		DATE SIGNED <i>11/10/51</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>burial</i>		DATE THEREOF <i>Jan. 11, 1952</i>	
NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cem.</i>		LOCATION (City, town, or county) <i>Trappe Rd. Ind.</i>	
DATE REC'D BY LOCAL REG. <i>1/10/51</i>		24. FUNERAL DIRECTOR <i>Wendell J. Supple</i>	
REGISTRAR'S SIGNATURE <i>A. W. Redick</i>		ADDRESS <i>315 S. High St. Ind.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

ST

290679

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cicadedio</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Cicadedio</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>616 Harwood Avenue</u>	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>G.</u> (Last) <u>St. Clair</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 7, 1874</u>
9. AGE last birthday <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labrator</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Marys Co. Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Francis M. St Clair</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wingate</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Ronald S. Hampt, Upper Md</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
Immediate cause (a) <u>Coronary Occlusion</u>		
Antecedent cause(s) (b) <u>Chr Myocarditis</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov 29, 1950, to Jan 29, 1951, that I last saw the deceased alive on Jan 29, 1951, and that death occurred at 10 A. m., from the causes and on the date stated above.

SIGNATURE <u>Joseph E. Bush</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>Wilmington Md</u>		DATE SIGNED <u>1/29/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>1/31/51</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
LOCATION (City, town, or county) <u>Woodlawn, Maryland</u>		24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	
DATE RECD BY LOCAL REG. <u>1/31/51</u>		REGISTRAR'S SIGNATURE <u>How. Hedrick</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

970469

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Parkville-rural Balto. 68 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Parkville-rural Balto.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3016 Taylor Avenue		STREET ADDRESS (If rural, give location) 3016 Taylor Avenue	
3. NAME OF DECEASED (Type or Print) IDA (First) M. (Middle) STANSBURY/ SANSBURY (Last)		4. DATE OF DEATH (Month) (Day) (Year) 1 - 4 - 51 19	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH Jan. 24, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Wolfe		14. MOTHER'S MAIDEN NAME Amelia Schraeder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Mrs. Wm.H. Hutton - 3212 Kenyon Ave.		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cerebral Hemorrhage		Immediate
Antecedent cause(s) (b) Hypertensive cardiovascular disease		?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 4, 1944**, to **Jan. 4, 1951**, that I last saw the deceased alive on **Dec. 15, 1950**, and that death occurred at **8 P.M.**, from the causes and on the date stated above.

SIGNATURE Harold G. Groth, M.D.		ADDRESS 8100 Hayford Rd. - 1/5/51	
23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE 1/8/51	NAME OF CEMETERY OR CREMATORY Western Cemetery	LOCATION (City, town, or county) (State) Baltimore, Md.
DATE REC'D BY LOCAL REG. 1/8/51	REGISTRAR'S SIGNATURE A. W. Redner	24. FUNERAL DIRECTOR HENRY SANDER & SONS INC. ADDRESS BALTO. 13, MD. Sander	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>605 N. Central Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>HARRY</u> (Middle) <u>E.</u> (Last) <u>SCHOFIELD</u>	4. DATE OF DEATH (Month) <u>January</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married Sep.</u>	8. DATE OF BIRTH <u>11-9-95</u>
9. AGE last birthday <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Noah Schofield</u>		14. MOTHER'S MAIDEN NAME <u>Grace Mary/Dennis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>219-12-9123</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<p>420.0 Immediate cause (a) <u>ARTERIOSCLEROTIC HEART DISEASE WITH DECOMPENSATION AND UREMIA</u></p> <p>93d Antecedent cause(s) (b) <u>Chronic Emphysema</u></p> <p>(c) <u>Renal Pathology, type undetermined</u></p>		<u>Unknown</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>unknown</u> <u>unknown</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 12, 1950, to Jan. 16, 1951, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

SIGNATURE M. E. Parrelly, M.D. ADDRESS VAH Fort Howard, Md. DATE SIGNED 11-16-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-18-51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/12/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Charles R. Law</u>	ADDRESS <u>802 Madison Ave., Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0291

Reg. Dist. No. *42*

1. PLACE OF DEATH COUNTY <i>BALTO</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MD</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Abutus</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Abutus</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>5561 Oregon Ave.</i>		STREET ADDRESS (If rural, give location) <i>5561 Oregon Ave</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Edwin F.</i> (Middle) <i>SEVERN</i> (Last)	4. DATE OF DEATH (Month) <i>1</i> (Day) <i>7</i> (Year) <i>51</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>12-10-1901</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Estimator - Naval de. Lab.</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>49</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John T.</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET E. BRANDENBURG</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <i>FAMILY - SAME</i>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause	(a) <i>Coronary Thrombosis</i>	1 day	
420.1 Antecedent cause(s)	(b) <i>Obesity</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE	INJURY		
HOMICIDE			
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
OF INJURY			

22. I hereby certify that I attended the deceased from *June 26, 1949*, to *Jan. 7, 1951*, that I last saw the deceased alive on *Jan 4*, 1951, and that death occurred at *4:45 P.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>B</i>	<i>1-11-51</i>	<i>Morgan Chaps</i>	<i>Woodbine, MD</i>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>1/9/51</i>	<i>G. A. Schube</i>	<i>James L. Schube</i>	<i>130 S. Fort Ave. 390916</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Monte</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard, Md.</u>		LENGTH OF STAY (in this place) <u>20 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Damascus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>				STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print) <u>CHARLES T. SHECKELS ALSO SHECKLES</u>		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 17 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>2-24-95</u>	9. AGE last birthday <u>55</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>printer / painter - worked for contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Damascus Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Nathan Sheckels</u>		14. MOTHER'S MAIDEN NAME <u>Edith Bowen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW-1 yes</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT AND ADDRESS <u>Clinical Records Vets. Adm. Hosp. Ft. Howard, Md.</u>		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

334x Immediate cause (a) CEREBRAL ARTERIOSCLEROSIS

Unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Oligodendroglioma, left frontal lobe
sequelae of (removal surgically 1947)

Unknown

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 27, 1950, to Jan. 17, 1951, that I last saw the deceasedlive on and that death occurred at 3:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Frank E. Pool, M.D. (A.D.)VAH Fort Howard, Md.1-17-51

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 17 '51 Dawson L. BarberRoy W. Barber Funeral Home, Laytonsville, Md.

564246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JAN 23 1951

BEAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0293

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Larchmont</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>2605 Poplar Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ANNA</u>	(Middle) <u>KATHERINE</u>	(Last) <u>SHELLHAS</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 11, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>86</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>Michael Arndt</u>		14. MOTHER'S MAIDEN NAME <u>Amelia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>(If year, give war or dates of service)</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Edna L. Hughes - 2605 Poplar Drive</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
22.1 Immediate cause	(a) <u>Myocardial failure</u>	<u>24 hours</u>	
932 Antecedent cause(s)	(b) <u>Arteriosclerotic cordis vasc. disease</u>	<u>Unknown</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility; decubitus ulcers</u>			<u>Unknown</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 26, 1951, to Jan 27, 1951, that I last saw the deceased alive on Jan 26, 1951, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1/30/51</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	LOCATION (City, town, or county) <u>Woodlawn, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>1/30/51</u>	REGISTRAR'S SIGNATURE <u>W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Wm. J. Schaner & Sons</u>	ADDRESS <u>Balto Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

0294

1. PLACE OF DEATH - COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Baltimore Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Offutt Memorial Home</u>		STREET ADDRESS <u>2 years</u>	
3. NAME OF DECEASED (Type or Print) <u>BETTY</u>	(First) (Middle) (Last) <u>SHRIVER</u>	4. DATE OF DEATH JAN. 5 1951	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>August 7, 1870</u> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustus Shriver</u>		14. MOTHER'S MAIDEN NAME <u>CAROLYN HAYNES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mr. E. Edgar Thompson Jr. Quaker 42nd</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Cerebral Accident</u>			<u>1</u> <u>years</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Hypertension</u>			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1949</u> 19... to <u>5 Jan.</u> 1951, that I last saw the deceased alive on <u>5 Jan.</u> 1951, and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Walter T. Kees</u>		DATE SIGNED <u>5 Jan. 1951</u>	
M.D. <u>M.D.</u>			
LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan. 6, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Wood Ridge</u>		LOCATION (City, town, or county) (State) <u>Bluesville, Baltimore Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 6/51</u>		24. FUNERAL DIRECTOR <u>Sanderson M. Brooks, Sparks, Md.</u>	
REGISTRAR'S SIGNATURE <u>Wm. J. Chilcoat</u>		ADDRESS <u>720826</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0295 44

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Warton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>LOUIS</u> (First) <u>R.</u> (Middle) <u>SILCOX</u> (Last)		4. DATE OF DEATH <u>Jan. 8</u> (Month) <u>1951</u> (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>6-27-93</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>57</u> yrs. If under 1 year Months Days Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>Ea Chestertown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Silcox</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW-1</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Right hemiplegia - cerebro-vascular accident</u>	<u>1 day</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Cardiovascular dis. with hypertension</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>auricular fibrillation, systoles; diabetes mellitus</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 8, 1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov. 27, 1950, to Jan. 8, 1951, and that death occurred at 7:05 P.m., from the causes and on the date stated above.

SIGNATURE <u>Paul Padget</u>	(Degree or title)	ADDRESS	DATE SIGNED
PAUL PADGET, M.D. CHIEF MEDICAL SERVICE VAH FT. HOWARD, MD.			<u>1-9-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>1-11-51</u>	NAME OF CEMETERY OR CREMATORY <u>Still Pond Cemetery</u>	LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 9, 51</u>	REGISTRAR'S SIGNATURE <u>L. Lawson L. Harbor</u>	24. FUNERAL DIRECTOR <u>B.R. Fellows</u>	ADDRESS <u>Still Pond Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

270116

914D

JAN 12 1951
REAU 7.8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for changes
in 8 & 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0296

FILM No. G 130 JAN 29 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>903 Dulaney Valley Court</u>		STREET ADDRESS (If rural, give location) <u>903 Dulaney Valley Court</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EMMA</u> (Middle) <u>W. P.</u> (Last) <u>SLACK</u>	4. DATE OF DEATH	(Month) <u>1</u> (Day) <u>18</u> (Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 9, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>59</u> yrs.	If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Pittsburgh Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Patton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Staley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. W. R. McClellan 903 Dulaney Valley Ct.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
153x Immediate cause (a) <u>Carcinoma of Intestinal tract.</u>		
Antecedent cause(s) (b) <u>Metastasis thru whole Intestinal tract.</u>		
462 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Metastasis thru whole Intestinal tract.</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Intestines</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1950, to Jan. 17, 1951, that I last saw the deceased alive on Jan. 17, 1951, and that death occurred at 5 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE <u>1/20/51</u>	NAME OF CEMETERY OR CREMATORY <u>Louisa Pk. Crematory</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>January 20, 1951</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>Wm. J. Tackner, 1000 E. Baltimore St.</u>	ADDRESS	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY BALTO. CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 59 BURKE AVE.		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD. COUNTY BALTO CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON TOWN STREET ADDRESS (If rural, give location) 59 BURKE AVE.	
3. NAME OF DECEASED (Type or Print) CATHERINE (First) G. (Middle) SLADE (Last)		4. DATE OF DEATH (Month) 1 (Day) 10 (Year) 1951	
5. SEX F	6. COLOR OR RACE W	7. <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED, <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED, (Specify)	8. DATE OF BIRTH JUNE 30, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 84 yrs. If under 1 year Months Days If under 24 hrs. Hours Mln.
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BENJAMIN CHASE		14. MOTHER'S MAIDEN NAME JULIA FARRELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS MRS. W. CATHELL		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Adenocarcinoma of fundus uteri**

INTERVAL BETWEEN ONSET AND DEATH

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Utero-colic fistula**

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hypertensive cardiovascular disease

19a. DATE OF OPERATION

Dec. 28, 1948

19b. MAJOR FINDINGS OF OPERATION

Adenocarcinoma of fundus uteri

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec. 28, 1948**, to **Jan. 4, 1951**, that I last saw the deceased

alive on **Jan. 4, 1951**, and that death occurred at **10:30 P.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

C. Bernard Brack, M.D. 11 E. Chase St.

Jan. 11, 1951

23. BURIAL CREMATION REMOVAL (Specify)

BURIAL

DATE THEREOF

1-13-1951

NAME OF CEMETERY OR CREMATORY

WILSON'S CHURCH CEM.

LOCATION (City, town, or county)

BALTO. Co.

(State)

MD.

DATE REC'D BY LOCAL REG.

1/11/51

REGISTRAR'S SIGNATURE

C. W. Brack

24. FUNERAL DIRECTOR

H.W. JENKINS & SONS Co.

ADDRESS

4905 YORK RD.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. BRACK
H. E. CHASE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

0274

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Severna Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>HENRY</u>	(Middle)	(Last) <u>SMITH</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 28, 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>packer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Candy company</u>	9. AGE last birthday <u>80</u> yrs. <u>10</u> months <u>3</u> days
11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Henry Smith</u>		14. MOTHER'S MAIDEN NAME <u>Anna Maria Easter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Records, Catonsville 28, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Arteriosclerotic heart disease

Antecedent cause(s)

(b) Pulmonary Fibrosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Senility

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐
(STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 1....., 1950., to Jan. 24., 1951., that I last saw the deceased

alive on Jan. 24....., 1951., and that death occurred at 5:30 a......m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal to rest.</u>	<u>1/25/51</u>	<u>University Med School</u>	<u>Baltimore</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1-25-51</u>	<u>V. E. Harvey</u>	<u>Francis A. Hensley</u>	<u>578 N. Biddle St.</u>	

690417

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

446



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9/

0298

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Granite</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Granite</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Davis Ave.</u>		STREET ADDRESS (If rural, give location) <u>Davis Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>RICHARD</u> (First) <u>C.</u> (Middle) <u>SMITH</u> (Last)		4. DATE OF DEATH <u>Jan. 9, 1951</u> (Month) (Day) (Year)	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan. 15, 1886</u>
9. AGE last birthday <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>baker's helper</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>baker's helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-10-6720</u>	
17. INFORMANT AND ADDRESS <u>Mr. Thomas Smith-Greenspring Drive, Lutherville, Md.</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>Coronary obstruction (occlusion)</u>	<u>1 hour</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Cardiovascular Disease</u>	<u>?</u>
(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/9/, 1951, to 1/9/, 1951, that I last saw the deceased alive on 1/9/, 1951, and that death occurred at 300 m., from the causes and on the date stated above.

SIGNATURE Wm. E. Martin (Degree or title) ADDRESS M. W. Randalltown Md DATE SIGNED 1/9/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/11/51</u>	NAME OF CEMETERY OR CREMATORY <u>Louden Park Cem.</u>	LOCATION (City, town, or county) <u>Balto., Md.</u>
DATE REC'D BY LOCAL REG. <u>1/9/51</u>	REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>	24. FUNERAL DIRECTOR <u>Wm. J. Lickner & Son - Balto.</u>	ADDRESS <u>500 416 md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0299

30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u> LENGTH OF STAY (in this place) <u>18 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>2505 N. Charles Street</u>	
3. NAME OF DECEASED (Type or Print) <u>HARRY BATES SOPER</u>		4. DATE OF DEATH <u>Jan. 24 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 23, 1879</u>
9. AGE last birthday <u>72</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Retired Banking</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Francis A. Soper</u>		14. MOTHER'S MAIDEN NAME <u>Clara Bates</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Records, Catonsville, 28, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cachexia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Initiation and dehydration

(c) Arteriosclerotic cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 8, 1951, to Jan. 24, 1951, that I last saw the deceased

alive on Jan. 24, 1951, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/26/51</u>	REGISTRAR'S SIGNATURE <u>R. W. Redner</u>	24. FUNERAL DIRECTOR <u>Wm. J. Schaner & Sons - Balt</u>	ADDRESS	

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MARGIN RESERVED FOR BINDING

VS. A151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>54 Main Street</u>		STREET ADDRESS <u>54 Main Street</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>William</u> (Middle) <u>I</u> (Last) <u>Stevenson</u>		(Month) <u>Jan.</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 9, 1882</u> 68 yrs.
9. AGE last birthday If under 1 year Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Deputy Register Wills</u>	
11. BIRTHPLACE (State or foreign country) <u>Reisterstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George H. Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Levia A. Gettier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Viola K. Stevenson, Reisterstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

3 yrs.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
<u>None</u>		<u>None</u>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
<u>None</u>		<u>None</u>		<u>None</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
<u>None</u> m.		<u>None</u>		<u>None</u>	

22. I hereby certify that I attended the deceased from 1-8, 1948, to 1-14, 1951, that I last saw the deceasedalive on 1-13, 1951, and that death occurred at 1 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

D. D. CaplesM.D.Reisterstown, Md.1-15-51

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 17, 1951</u>		<u>Reisterstown Methodist</u>		<u>Reisterstown, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-16-51</u>		<u>Mary B. Eline</u>		<u>J.F. Eline & Sons</u>		<u>Reisterstown, Md.</u>	

250936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 10 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Maryland Balto.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1300 Andre St.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
JESSE	(NMI)	STUPINSKI	
4. DATE OF DEATH	(Month)	(Day)	(Year)
Jan.	9	1951	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	white	married	11-24-13
9. AGE last birthday	If under 1 year Months	If under 24 hrs. Days	Hours Min.
37 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stevedore</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony Stupinski</u>		14. MOTHER'S MAIDEN NAME <u>Helen Motzleska</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes</u> <u>WW-2</u>		16. SOCIAL SECURITY No. <u>222-07-0417</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute Hepatitis

INTERVAL BETWEEN ONSET AND DEATH

3 wks.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that VA attended the deceased from Jan. 8, 1951, to Jan. 9, 1951, that last saw the deceased

alive on Jan. 8, and that death occurred at 12:25 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

IRVING FREEMAN, M.D., ACTING CHIEF MEDICAL SERVICE VAH FT. HOWARD, MD. 1-9-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1-12-51	Balto. National Cemetery	5501 Frederick Ave.	Balto. Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
1/11/51	<u>R. W. Hedman</u>	Mrs. Chas. Stevens 1501 E. Fort Ave. Balto. Md.		

Charles J. Dill Surgeon

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0302

1. PLACE OF DEATH- COUNTY <u>Parkville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3006 Putty Hill Avenue</u>		STREET ADDRESS (If rural, give location) <u>3006 Putty Hill Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frances</u> (Middle) <u>T.</u> (Last) <u>Sumwalt</u>	4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Apr. 12, 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>81</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. John Nolan, 3006 Putty Hill Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Myocardial Insufficiency

Antecedent cause(s)

(b)

Arteriosclerosis, Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Myocarditis, Epithelionia Sculp.

INTERVAL BETWEEN ONSET AND DEATH

about 10 hrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT, SUICIDE, HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1950, to Jan 15, 1951, that I last saw the deceased

alive on Jan 13, 1951, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. G. Scheuch M.D.

1337 S. Charles St

1/17/51

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1/12/51

W. Hedrick

Leonard J. Ruck, 5305 Harford Road.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Scheurich

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

51

19.

51

19.

51

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51

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51

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51

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51

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51

19.

51

19.

51

19.

51

19.

51

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 27th 1951 at 7¹⁵ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1st 1951 to Jan 27 1951

and that I last saw him alive on Jan 26 1951

Immediate cause of death: Myocardial infarction

DURATION 30 days

Due to: Old age

Due to:

Other conditions:

4222

(Include pregnancy within 3 months of death)

932

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. C. LinnickAddress: 4509 Liberty Heights AveDate signed: Jan 28

1290116

Registrar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY <u>Balto</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lincolnton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cokee Lincolnton</u>	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3 Northwood Lane</u>		STREET ADDRESS (If rural give location) <u>3 Northwood Dr.</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles</u>		(Last) <u>Tracey</u>	
(First) <u>Charles</u>		(Middle) <u>Spencer</u>	
5. SEX <u>Male</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>5</u> (Year) <u>1951</u>	
6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>3-27-1885</u>		9. AGE last birthday <u>65</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mgg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel S. Tracey</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Grimm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>218-08-7980</u>	
(If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Jennie Tracey, Lincolnton, Md</u>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause (a) <u>Coronary Thrombosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a (b) <u>None</u>	
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)
SUICIDE	INJURY
HOMICIDE	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED
OF	While at Not While
INJURY	Work <input type="checkbox"/> At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>50</u> , to <u>1/5</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>51</u> , and that death occurred at <u>9:45</u> m., from the causes and on the date stated above.	
SIGNATURE	ADDRESS
<u>William C. Eason M.D.</u>	<u>1/5/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF
<u>Burial</u>	<u>1-8-51</u>
NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Delmont</u>	<u>Spark, Balto Co. Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE
<u>Jan 6/51</u>	<u>J. Chilcoat</u>
24. FUNERAL DIRECTOR	ADDRESS
<u>L. Scott Brooks</u>	<u>Spark, Md.</u>

390499

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51
66
85

REF ID:
JAN 9 1951
FBI WASH. D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Jellowsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Jellowsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 923 Arran Rd.				STREET ADDRESS 923 Arran Rd. (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH
WILLIAM		HENRY	TULLY	Jan.	23, 19 51
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed		8. DATE OF BIRTH Aug. 27, 1898	9. AGE last birthday 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Contractors		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Wm. H. Tully		14. MOTHER'S MAIDEN NAME Winifred A. Flanigan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY No. 215-01-7410		17. INFORMANT AND ADDRESS Mrs. Wm. Sullivan - 923 Arran Rd.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **ARTERIO SCLEROsis.**

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last(b) **CHR. INTESTINAL ULCER.**

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **12-20**, 19**50**, to **1-23**, 19**51**, that I last saw the deceasedalive on **1-23**, 19**51**, and that death occurred at **8: A.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1/27/51	NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.	LOCATION (City, town, or county) Balto., Md.	(State)
DATE REG'D BY LOCAL REG. 1/28/51	REGISTRAR'S SIGNATURE A.W. Hedrick	24. FUNERAL DIRECTOR Wm. J. Lickner & Sons - Balto Md	ADDRESS 554 246	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

0306

1. PLACE OF DEATH COUNTY <u>Baets Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Baets Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
TOWN <u>Catonsville</u>		TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>		STREET ADDRESS (If rural, give location) <u>124 Newburg</u>	
3. NAME OF DECEASED (Type or Print) <u>Bruce A. Underwood</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct 11/1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Genl. Surg.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u>	9. AGE last birthday <u>76</u> yrs.
13. FATHER'S NAME <u>Almeron Underwood</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT AND ADDRESS <u>Miss Margorie Underwood</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
163x Immediate cause (a) <u>Carcinoma of the lung</u>			<u>6-12 months</u>
47d Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
11. OTHER SIGNIFICANT CONDITIONS (c) <u>atherosclerotic cardiovascular disease</u>			<u>5 yrs</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1 Dec, 1950, to 17 Jan, 1951, that I last saw the deceased alive on 17 Jan, 1951, and that death occurred at 4:55 P.M., from the causes and on the date stated above.

SIGNATURE John A. Healy Jr. (Degree or title) MD ADDRESS 20 E Preston St, Balt. 2, Md DATE SIGNED 20 Jan 51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/20/51</u>	<u>London Park</u>	<u>Baets Co MD</u>
DATE REC'D BY LOCAL REG. <u>1-20-51</u>	REGISTRAR'S SIGNATURE <u>V E. Harry</u>	FUNERAL DIRECTOR <u>Mac Webb & Son</u>	ADDRESS

043246

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Woodlawn TOWN Woodlawn HOSPITAL OR INSTITUTION OR STREET ADDRESS 2100 Northland Road		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Woodlawn TOWN Woodlawn STREET ADDRESS (If rural give location) 2100 Northland Road	
3. NAME OF DECEASED (Type or Print) Wyllette King Van Rhyn		4. DATE OF DEATH (Month) (Day) (Year) Jan. 17, 1951	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH June 28, 1884
9. AGE last birthday 66 yrs.		10. If under 1 year (Months) (Days) (Hours) (Min.) 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lucian L. King		14. MOTHER'S MAIDEN NAME Henrietta O. Gibson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT Mrs. Charles M. Stumpner, 2100 Northland Rd			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause (a) Carcinoma, right breast	
Antecedent cause(s) (b) Arteriosclerosis	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE INJURY	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **July 26, 1950**, to **Jan. 17, 1951**, that I last saw the deceased alive on **Jan. 12, 1951**, and that death occurred at **9:45 A.M.**, from the causes and on the date stated above.

SIGNATURE **Dr. McLaughlin** (Degree or title) ADDRESS **4508 Edmondson Millage** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1 - 20 - 51	NAME OF CEMETERY OR CREMATORY Woodlawn	LOCATION (City, town, or county) (State) Woodlawn, Md.
DATE REC'D BY LOCAL REG. 1-19-51	REGISTRAR'S SIGNATURE L	24. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc.	ADDRESS 1900 Eutaw Place Baltimore, Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0308 43
Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
TOWN <u>Overlea</u>		TOWN <u>Overlea</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>13. Belinda Ave</u>		STREET ADDRESS (If rural give location) <u>13 Belinda Ave</u>	
3. NAME OF DECEASED (First) <u>Sarah</u> (Middle) <u>Vogel</u> (Last) <u>Vogel</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 23 - 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN. Home</u>	9. AGE last birthday <u>77</u> yrs. If under 1 year Months Days Hours Min.
13. FATHER'S NAME <u>Silverne Carley</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
16. SOCIAL SECURITY No. <u>---</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Peubert</u>	
17. INFORMANT <u>Earl Fisher 17th & Washington Blvd</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>4 days</u>
Antecedent cause(s) (b) <u>Hypertensive - arteriosclerotic heart disease</u>		<u>15 yrs.</u>
(c) <u>420.0</u> <u>932</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 4, 1951, to Jan 8, 1951, that I last saw the deceased alive on Jan 8, 1951, and that death occurred at 9:40 A.M. m., from the causes and on the date stated above.

SIGNATURE Adam Glavis M.D. ADDRESS 6232 Belair Rd. Balt Md DATE SIGNED Jan 8, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/11/51</u>	<u>Memorial Shrine</u>	<u>Easton Pa</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/8/51</u>	<u>A. W. Hedrick</u>	<u>Lassahn Funeral Home</u>	<u>7401 Belair Rd Baltimore</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: **Baltimore**
 County.....
 City or town..... **Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
244 Glenmore Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Ma.** County.....
 City or town..... **Baltimore City**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **3217 St. Paul St.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME
Anna Marie Wagner

3. (b) Social Security Number

4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**
 6. (b) Name of husband or wife..... **Charles W. Wagner**

7. Birth date of deceased (mo., day, yr.) **Jan. 29, 1875** 6. (c) If alive, give age..... years

8. AGE: Years **75** Months Days If less than one day
hrs.min.

9. Birthplace **Baltimore, Md.**
 (Town, county, and state)
H. W.

10. Usual occupation.....

11. Industry or business **Own Home**

FATHER 12. Name **James Concannon** 13. Birthplace **Md.**

MOTHER 14. Maiden name..... **Unknown** 15. Birthplace **Md.**

16. Informant..... **Mrs. Joseph Tull, (daughter)**
 Address **244 Glenmore Ave. Catonsville, Md.**

17. Burial (Burial, cremation, or removal, Which?) Date thereof..... **Jan. 20/51**
 (month) (day) (year)
 Cemetery or crematory **St. Mary's Cemetery**
 Location **Homewood Ave. Govans, Balto. Md.**

18. Funeral director..... **Harry A. Witte**
 Address **4101 Edmondson Ave.**

19. **1-19** 19**51** **V.E. Harry** Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Jan. 18/51** 19..... at **7:30 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Dec 23** 19**50** to **Jan 18** 19**51**
 and that I last saw him alive on **Jan 18** 19**51**

Immediate cause of death..... **Degenerative Cardio Vas. Disease** DURATION **5 yrs**

Due to **Hypertension** **2 yrs**

Due to **Arterio Sclerosis**

Other conditions..... **403x**
93d (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... **James Estouree** M. D. or other
 Address..... **Catonsville** Date signed **1-19**

RECEIVED
JAN 29 1951
U. S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

0310

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Jefferson, P.D.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arcadia</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>XXX</u>		STREET ADDRESS (If rural give location) <u>Jefferson, P.D.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Henry</u> (Middle) <u>Barnelius</u> (Last) <u>Walleth</u>	4. DATE OF DEATH	(Month) <u>Jan</u> (Day) <u>26</u> (Year) <u>1951</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 7, 1914</u>
9. AGE last birthday <u>36</u> yrs.		10. If under 1 year: Months <u>3</u> Days <u>19</u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Walleth</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Ann Stanbury</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>216-22-7860A</u>	
(If yes, give war or dates of service)		17. INFORMANT <u>wife - Frances Walleth</u>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause <u>452x</u> <u>93d</u> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(a) <u>Angina Pectoris + Chronic Myocarditis</u> (b) <u>Intestinal Influenza</u> (c) <u>Chronic Arthritis</u>
INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>3 weeks</u> <u>20 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>XXX</u>	
19a. DATE OF OPERATION <u>XXX</u>	19b. MAJOR FINDINGS OF OPERATION <u>XXX</u>
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>XXX</u>	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>XXX</u>
(CITY OR TOWN) <u>XXX</u>	(COUNTY) <u>XXX</u>
(STATE) <u>XXX</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>X</u> <u>X</u> <u>X</u> <u>X</u> <u>h.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>
HOW DID INJURY OCCUR? <u>XXX</u>	
22. I hereby certify that I attended the deceased from <u>Jan 8</u> , 19 <u>51</u> , to <u>Jan 26</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>51</u> , and that death occurred at <u>2</u> <u>P.</u> m., from the causes and on the date stated above.	
SIGNATURE <u>April E. Forable M.D.</u>	DATE SIGNED <u>Jan 26 - 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>Jan 27/51</u>
NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	LOCATION (City, town, or county) (State) <u>Balto Co Md</u>
DATE REC'D BY LOCAL REG. <u>1-27-51</u>	REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>
24. FUNERAL DIRECTOR <u>Edwin E. Dutton</u>	ADDRESS <u>Hampstead Md</u>

970116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1706 Woodbourne Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES M. WARD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 5 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8-18-89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland Penitentiary</u>	9. AGE last birthday <u>61</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Ward</u>		14. MOTHER'S MAIDEN NAME <u>May Healey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY No. <u>215-24-6363</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>CARCINOMA OF THE STOMACH WITH METASTASES TO LIVER</u>		<u>4 months +</u>
Antecedent cause(s) (b) <u>None</u>		
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 15, 1950, to Jan. 5, 1951, that I last saw the deceased

None and that death occurred at 2:30 A. M., from the causes and on the date stated above.

SIGNATURE Irving Freeman (Degree or title) ADDRESS 1-5-51 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/8/51</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG. <u>1/8/51</u>	REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Leonard Ruck</u>	ADDRESS <u>5305 Harford Road Baltimore, Maryland</u>

JT

763926

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0311

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 33

Nellie White

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Delight & Nicodemus Rds.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>NELLIE</u> (Middle) <u>GRANT</u> (Last) <u>WHITE</u>		4. DATE OF DEATH (Month) <u>Jan. 12,</u> (Day) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 11 1871</u>
9. AGE last birthday <u>79</u> yrs.		10. DATE OF BIRTH <u>Oct. 11 1871</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawrence Rice</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mr. E. E. White</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260x Immediate cause (a) <u>Coronary artery Disease</u>		<u>1 1/2</u>	
61 Antecedent cause(s) (b) <u>Hypertensive C.V. Disease</u>		<u>2 yrs.</u>	
(c) <u>Diabetes</u>		<u>3 yrs.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None.</u>			
19a. DATE OF OPERATION <u>None.</u>		19b. MAJOR FINDINGS OF OPERATION <u>None.</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>None.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None.</u>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>D. D. Gables Deputy Md. Exam</u>		DATE SIGNED <u>1-12-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/15/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Pk. Cem</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>1-14-51</u>		24. FUNERAL DIRECTOR <u>Wm. J. Tucker, Sons Inc</u>	
REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		ADDRESS <u>Balto Md</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Towson Convalescent Home</u>		STREET ADDRESS (If rural, give location) <u>302 Tunbridge Rd.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>May</u> <u>Field</u> <u>WHITESCARVER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN</u> <u>4</u> <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Dec. 18, 1860</u>
9. AGE last birthday <u>90</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>At. Home</u>	
13. FATHER'S NAME <u>James G. Field</u>		14. MOTHER'S MAIDEN NAME <u>Frances Cowherd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James F. Whitescarver, 302 Tunbridge Rd.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Antecedent cause(s)

(b) GENERALIZED ARTERIOSCLEROSIS(c) 422. 1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause lastII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not White <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from JULY, 1949, to JAN 4, 1951, that I last saw the deceased alive on JAN 4, 1951, and that death occurred at 11 50 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>1/5/51</u>	<u>Orange</u>	<u>Orange Va</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1/5/51</u>	<u>H.W. Medical</u>	<u>Wm. C. McK</u>	<u>1217 S. Paul St</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

0314

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Riderwood		CITY (If outside corporate limits, write RURAL and give nearest town) Riderwood	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Riderwood Station		STREET ADDRESS (If rural, give location) Riderwood Station	
3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) WESLEY	(Last) WILEY
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 10, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Private Employee	
13. FATHER'S NAME Clark Wiley		14. MOTHER'S MAIDEN NAME Mary Elizabeth McCleary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. #	
17. INFORMANT AND ADDRESS Mr. Oscar Wiley, Towson, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
9. AGE last birthday 83 yrs.		4. DATE OF DEATH Jan. 23, 1951	
11. BIRTHPLACE (State or foreign country) Maryland		1. DATE (Month) (Day) (Year) Jan. 23, 1951	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
Immediate cause 420.1 Coronary Occlusion		(a) Coronary Occlusion			
Antecedent cause(s) 94a. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) Arterio-sclerosis & Hypertension			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		(c)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec 27 , 19 50 , to Jan 23 , 19 51 , that I last saw the deceased alive on Dec 26 , 19 51 , and that death occurred at 11:15 A.M. , from the causes and on the date stated above.					
SIGNATURE John H. Burns		ADDRESS Towson, Md.		DATE SIGNED 1/24/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE Jan. 26, 1951		NAME OF CEMETERY OR CREMATORY Weisburg Methodist Cemetery	
DATE REC'D BY LOCAL REG. 1-24-51		REGISTRAR'S SIGNATURE A. W. K. Smith		24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland	

763826

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0315

1. PLACE OF DEATH- COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltz</u> TOWN <u>Beltz</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5121 Bolling Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltz</u> TOWN <u>Beltz</u> STREET ADDRESS (If rural, give location) <u>5121 Bolling Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>PHELPS</u>	(Middle) <u>RICHARD</u>	(Last) <u>WILSON</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 23, 1857</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Station Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	9. AGE last birthday <u>93</u> yrs. <u>Jan. 14, 1951</u>
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Spencer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Gertrude A. Pfeiffer Same as above</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334x Immediate cause (a) Cerebral arterio sclerosis
Antecedent cause(s) (b) Dehydration due to inability to
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) swallow

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>✓</u>	19b. MAJOR FINDINGS OF OPERATION <u>✓</u>	20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>
21. ACCIDENT (Specify) <u>✓</u> SUICIDE <u>✓</u> HOMICIDE <u>✓</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>✓</u> INJURY <u>✓</u>	(CITY OR TOWN) <u>Beltz</u> (COUNTY) <u>Balto</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u> m.	INJURY OCCURRED While at <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19.55, to Jan. 14, 1951, that I last saw the deceased alive on Jan. 14, 1951, and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE Frederic V. Benter MD. ADDRESS 723 Mercie Gts Bldg - Balt. Md. 1-16-51 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/17/51</u>	NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>	LOCATION (City, town, or county) <u>Woodlawn, Md.</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>1/17/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Wm. J. Jackson & Son Inc. Balt. Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

380506

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>REISTERSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>REISTERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WESTMINSTER Rd.</u>		STREET ADDRESS (If rural give location) <u>WESTMINSTER Road. Route 2</u>	
3. NAME OF DECEASED (Type or Print) <u>LOUIS</u> (First) (Middle) (Last) <u>WINTERS</u>		4. DATE OF DEATH <u>JANUARY 6</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4/27/1879</u>
9. AGE last birthday <u>71</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER tenant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE last birthday <u>71</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	13. FATHER'S NAME <u>Christian Winters</u>	
14. MOTHER'S MAIDEN NAME <u>Meta Grothere</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. <u>(blank)</u>		17. INFORMANT <u>Ludwig C. Winters, Reisterstown, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>BRONCHO-PNEUMONIA</u>		<u>3 DAYS</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>CARCINOMA PECTUM</u>		<u>1 YEAR</u>
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>MARKED ARTERIOSCLEROSIS</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>4:00 A.M.</u> , 19 <u>50</u> , to <u>JANUARY 6</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>JANUARY 5</u> , 19 <u>51</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.		
SIGNATURE <u>Martin E. Strobel</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>Reisterstown, Md.</u> DATE SIGNED <u>1/6/51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan 8, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Matthews</u>
LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	DATE REC'D BY LOCAL REG. <u>1-6-51</u>	REGISTRAR'S SIGNATURE <u>Dary B. Elime</u>
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville, Md.</u>		ADDRESS <u>(blank)</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>M.D.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edmonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Edmonsville</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hallen Nursing Home</u>		STREET ADDRESS (If rural give location) <u>531 E. Fort Ave.</u>	
3. NAME OF DECEASED (First) <u>Grace</u>	(Middle) <u>Elizabeth</u>	(Last) <u>Wolf</u>	4. DATE OF DEATH (Month) <u>1.6</u> (Day) <u>.51</u> (Year) <u>19</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>2.27.1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>78</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Samuel Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Baltimore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Family - Same</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>CARDIAC FAILURE</u>			<u>4 days</u>
Antecedent cause(s) (b) <u>HYPERTENSION</u>			<u>YEARS</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>ARTERIOSCLEROSIS GENERALISED</u>			<u>YEARS</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>ARTERIOSCLEROTIC DEMENTIA</u>			<u>YEARS</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11/29, 1950, to 1/6, 1951, that I last saw the deceased alive on 1/15, 1951, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

SIGNATURE Wm. L. Williams II M.D. (Degree or title) ADDRESS 3534 Edmondson Cir DATE SIGNED 1/6/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>B</u>	DATE <u>1.9.51</u>	NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	LOCATION (City, town, or county) <u>Ballo.</u> (State)
DATE REC'D BY LOCAL REG. <u>4/9/51</u>	REGISTRAR'S SIGNATURE <u>G. W. Redlich</u>	24. FUNERAL DIRECTOR <u>James L. L. Lacey</u>	ADDRESS <u>130 E. Fort Ave.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>230 Glenmore Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balt0.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> STREET ADDRESS (If rural, give location) <u>230 Glenmore Ave.</u>	
3. NAME OF DECEASED (First) <u>Edwin</u> (Middle) <u>D.</u> (Last) <u>Woodall</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>6/51</u> (Year) <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 26, 1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>87</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Woodall</u>		14. MOTHER'S MAIDEN NAME <u>Amelia-----</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Mildred D. Workmann, 230 Glenmore Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

5 days

Antecedent cause(s)

(b)

Atherosclerosis, generalizedUnknown

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Senility

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Senility, fracture, left hip.Unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 May, 1950, to Jan 6, 1951, that I last saw the deceasedalive on 2 Jan, 1951, and that death occurred at 115 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1/9/51

A.W. Hedrick

2930 Frederick Ave.

4101 Edmondson Ave

ST ✓

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0319

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fowlesburg		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Towson	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Holliday House Nursing Home		STREET ADDRESS (If rural give location) Bonnie Hill and Burnbrae Roads	
3. NAME OF DECEASED (Type or Print)	(First) KATHERINE	(Middle) ANNA	(Last) ZEMAN
4. DATE OF DEATH	(Month) Jan.	(Day) 28,	(Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 16, 1868
9. AGE last birthday 82 yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Hefner	
14. MOTHER'S MAIDEN NAME Mary Schmidt		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY No. None		17. INFORMANT Joseph Zeman, Towson, Maryland	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Broncho PNEUMONIA**

INTERVAL BETWEEN ONSET AND DEATH

72 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **ARTERIOSCLEROTIC C.V. DISEASE**

YEARS

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

FRacture RT. FEMUR

6 WKS

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **N.O.V.**, 1950, to **JANUARY 28, 1951**, that I last saw the deceased

alive on **JAN. 27**, 1951, and that death occurred at **5:00 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Martin E. Strobel

M.D.

Reisterstown, Md.

1/28/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Jan. 30, 1951	NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	LOCATION (City, town, or county) Towson, Maryland	(State)
DATE REC'D BY LOCAL REG 1/29/51	REGISTRAR'S SIGNATURE John Redick	24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING